2020-2021 Insurance Information Form

The completion of this form is necessary for every vaccine recipient. If no insurance information is available, please fill out as much as possible using existing information.

Information about the person to receive vaccine (please print): *Required Fields

Name: (Last, First, MI)*	Date of birth: * ____ ____ ____ Month Day Year	Age*	Sex: (Circle)* Male Female
Street Address:*			
City:*	State: *	Zip:*	Phone:* ( )

Insurance Information: *Include the whole member ID number and any letters that are part of that number*

Name of Insurance Company:*	Member ID Number:*	Group ID Number: (if available)
Medicare Number:	Is Medicare Primary? Yes No	Is Subscriber Retired? Yes No

If person getting vaccinated is not the subscriber, please complete the following:

Subscriber's Name: (Last, First, MI)*	Subscriber's Date of Birth: * ____ ____ ____ Month Day Year	Sex: (Circle)* Male Female
Subscriber's Street Address:* (If different from address above)		
City:*	State:*	Zip: *	Phone:* ( )
Patient Relationship to Subscriber: (Circle)* Spouse Child Other		

I give permission for my insurance company to be billed. I give permission to be vaccinated.

X _____ Date: _____

(Signature of patient, parent or legal guardian)

For children 18 years of age and younger: Please check one of below

Is Vaccine for Children (VFC) Program eligible:

____ Is enrolled in Medicaid (includes MassHealth and HMOs etc. if enrolled through Medicaid)
____ Does not have health insurance
____ Is American Indian (Native American) or Alaska Native

Is not VFC-eligible:

____ Has health insurance and is not American Indian (Native American) or Alaska Native

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*** For Clinic/Office Use Only:**

Date of Service	Vax Type	Vaccine Mfgr	Lot No Exp date	Dose (mL)	State Supplied (Circle)	Preserv Free (Circle)	Injection Route (Circle)	Injection Site (Circle)	Date On VIS	Date VIS Given
	IIV4	Glaxo Smith Kline	275KY exp 6/30/2021	.5ml	YES	Yes	IM	R Arm L Arm R Leg L Leg	*8/15/19*	

Provider Name: North Attleboro Public Schools MDPH Provider PIN#: 14831

Provider Address: 564 Landry Avenue, North Attleboro MA 02760

Signature of Vaccine administrator_____ Date:_____