# 2020-2021 Flu 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 the Acton Nursing Services consent for the administration of the Influenza vaccine to myself or my child. I have answered the screening questions to the best of my ability.**

X _____ Date: _____

(Signature of patient, parent or legal guardian)

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***Place Photo Copy of All Insurance Cards Here:**

Provider Name: Acton Public Health Nursing Services MDPH Provider PIN#: 12045

Provider Address: 30 Sudbury Road, Rear, Acton, MA 01720

# 2020-2021 Flu Insurance Information Form

**For children 18 years of age and younger:**

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

**For Clinic/Office Use Only:**

| Date of Service | Vax Type | Vaccine Mfgr | Lot No | Exp Date | Dose (mL) | State Supplied (Circle) | Preserv Free | Injection Route (Circle) | Injection Site (Circle) | Date On VIS | Date VIS Given |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | IIV4 | Sanofi Pasteur | | | 0.25<br>0.5 | Yes<br>No | Yes<br>No | IM | R Arm L Arm<br>R Leg L Leg | 08/15/2019 | |
| | Fluzone HD QIV | Sanofi Pasteur | | | 0.5 | No | Yes | IM | R Arm<br>L Arm | 08/15/2019 | |
| | | | | | | | | | | | |

**For patients to be vaccinated:** The following questions will help us determine if there is any reason we should not give you or your child inactivated injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

| | Yes | No | Don't Know |
|---|---|---|---|
| 1. Is the person to be vaccinated sick today? | ____ | ____ | ____ |
| 2. Does the person being vaccinated have an allergy to eggs or to a Component of the vaccine? | ____ | ____ | ____ |
| 3. Has the person to be vaccinated ever had a serious reaction to the influenza vaccine in the past? | ____ | ____ | ____ |
| 4. Has the person to be vaccinated ever had Guillain Barre syndrome? | ____ | ____ | ____ |

**Signature of Vaccine Administrator: _____**

IV4 = Inactivated influenza vaccine, quadrivalent

HD QIV = Inactivated influenza vaccine, quadrivalent, high dose

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