INJECTABLE 2020-2021 Flu Vaccine 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 insurance subscriber/policy holder, 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.

X _____ Date: _____
(Signature of patient, parent or legal guardian)

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 (Circle)	Vax Type	Vaccine Mfgr	State Supplied (Circle)	Preserv Free*	Lot No	Exp Date	Dose (mL)	Injection Route (Circle)	Injection Site (Circle)	Date On VIS	Date VIS Given (Circle)
10/24/20 11/7/20 11/15/20	IIV4	GSK	Yes No	Yes	J3T44 494S5	6/30/21	0.5	IM	R Arm L Arm R Leg L Leg	8/15/19	10/24/20 11/7/20 11/15/20

Signature of Vaccine Administrator: _____

Provider Name: Brookline Department of Public Health MDPH Provider PIN#: 10187 Provider Address: 11 Pierce St., Brookline, MA, 02445

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Screening Checklist for Contraindications to Inactivated Injectable Influenza Vaccination

The following questions will help us determine if there is any reason we should not give you or your child inactivated injectable influenza vaccine 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 must 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. Has the person to be vaccinated ever had a serious allergic reaction after eating eggs?	☐	☐	☐
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	☐	☐	☐
4. Has the person to be vaccinated ever had Guillain-Barré syndrome (a type of temporary severe muscle weakness)?	☐	☐	☐
5. Does the person to be vaccinated have any serious allergies?	☐	☐	☐