2010 - 2011 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:* Saugus	State: * MA	Zip:* 01906	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)

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.

X _____ Date: _____

(Signature of patient, parent or legal guardian)

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For Clinic/Office Use Only:

Date vax given:	Seasonal Flu Vax Type	Vax Manufacturer	Vax Exp. Date & Lot No.	Dose No.	Preserv. Free	Injection Site & Route: (Circle)*		Date on VIS	Date VIS Given
	TIV LAIV			1 2 Amount:	Yes No	Intranasal R Arm L Arm R Leg L Leg	IM	August, 2010	

Clinic Site Name: Saugus Board of Health MDPH Provider PIN#: 11522

Clinic Address: 298 Central Street, Saugus, MA 01906

Signature of Vaccine Administrator: _____ Date: _____