

## 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: *	Age*	Sex: (Circle)*
	_____ Month    Day    Year		Male    Female
Email:	Race: (Circle) Asian    Black    White		
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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is Subscriber Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No

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

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

**I give permission for the administration of the influenza vaccine, were provided VIS/MIIS information, and for my insurance company to be billed.**

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

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- Attach a Photo Copy of Insurance Card(s)**

Provider Name: **Watertown Health Department**

MDPH Provider PIN#: **11736**

Clinic Address: **149 Main Street – Watertown, MA 02472**

## 2020 - 2021 Insurance Information Form

**For Children 18 years of age and younger: \***

<input type="checkbox"/> Is enrolled in Medicaid (Includes MassHealth and HMO's etc enrolled through Medicaid).
<input type="checkbox"/> Does not have health insurance.
<input type="checkbox"/> Is American Indian (Native American) or Alaska Native.
<input type="checkbox"/> Has health insurance and is not American Indian (Native American) or Alaska Native.

**Screening Questionnaire for 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 vaccine. This doesn't mean you cannot receive the vaccine today but additional questions will be asked. If a question is not clear please ask your healthcare provider to explain.

	Yes	No	Unknown
In the last 24 hours does the person to be vaccinated have any COVID-19 like symptoms? (fever, chills, cough, nasal congestion, headache, or difficulty breathing).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the person to be vaccinated have an allergy to eggs or to a component (thimerosal) of the vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the person to be vaccinated ever had a serious reaction to the influenza vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the person to be vaccinated ever had Guillain Barre Syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**For Clinic/Office Use Only:**

Date of Service:	Vax Type	Vax Mfgr	Exp. Date / Lot No	Dose	State Supplied	Preserv Free	Injection Route / Site (Circle)	Date On VIS	Date VIS/MIIS given
	IIV4	Sanofi	6/30/2021	0.5mL	NO	NO	IM LD RD	8/15/19	
	IIV4	Sanofi	6/30/2021	0.5ml	YES	NO	IM LD RD	8/15/19	

Signature of Vaccine Administrator: \_\_\_\_\_

Date: \_\_\_\_\_

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