

## 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:*	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)
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**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: * (    )
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			1    2	Yes	Intranasal    IM		
	LAIV			Amount:	No	R Arm    L Arm R Leg    L Leg		

Clinic Site Name: \_\_\_\_\_ MDPH Provider PIN#: \_\_\_\_\_

Clinic Address: \_\_\_\_\_

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

**Use the space below to record any additional information:** (optional)

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