2018-2019 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 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)

Massachusetts law (M.G.L. c. 111, Section 24M) requires providers to report immunization information to a computerized immunization registry known as the Massachusetts Immunization Information System (MIIS). The MIIS stores immunization records for you and your healthcare provider and can help prevent outbreaks of disease like measles and the flu. All information in the MIIS is kept secure and confidential. The MIIS allows information to be shared with health care providers, school nurses, local boards of health, and state agencies concerned with immunization. You have the right to object to the sharing of your immunization information across providers in the MIIS. For more information, please ask your healthcare provider, visit the MIIS website at www.mass.gov/dph/miis or contact the Massachusetts Immunization Program directly at 617-983-6800 or 888-658-2850.

Provider Name: _____Everett Health Department _____ MDPH Provider PIN#: ____10461_____

Provider Address: _____484 Broadway Rm 20 Everett, MA 02149_____

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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:

Signature of Vaccine Administrator: _____

Date of Service	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
	IIV4	Sanofi Pasteur	Yes No	Yes No	UI997AA	6/30/19	0.5 0.25	IM	R Arm L Arm R Leg L Leg	8/7/15	
	LAIV4	AstraZeneca	Yes No	Yes			0.2	Intranasal	N/A		
	Fluzone High Dose (IIV3-HD)	Sanofi Pasteur	No	Yes	UJ004AA	3/30/19	0.5	IM	R Arm L Arm	8/7/15	
	Flublok (RIV4)	Sanofi Pasteur	No	Yes	QFAA1810	6/30/19	0.5	IM	R Arm L Arm	8/7/15	

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