# 2014-2015 Senior 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 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)

**For Clinic/Office Use Only:**

**Signature of Vaccine Administrator:** ______________________________

| Date of Service | Vax Type | Vaccine Mfgr | Lot No | Exp Date | Dose (mL) | State Supplied (Circle) | Preserv Free | Injection Route (Circle) | Injection Site (Circle) | Date On VIS | Date VIS Given |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | IIV3 High Dose | Sanofi Pasteur | | | 0.5 | No | Yes | IM | R Arm L Arm | | |
| | IIV4 OR IIV3 | | | | 0.25 0.5 | Yes No | Yes No | IM | R Arm L Arm R Leg L Leg | | |
| | PPV23 | Merck | | | 0.5 | Yes No | N/A | IM SC | R Arm L Arm | | |

Provider Name: ______________________________ MDPH Provider PIN#: ____________

Provider Address:

______________________________________________