

2011 - 2012 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)*								
	<table style="margin: auto; border: none;"> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none; font-size: small;">Month</td> <td style="border: none; font-size: small;">Day</td> <td style="border: none; font-size: small;">Year</td> </tr> </table>	_____	_____	_____	Month	Day	Year		<table style="margin: auto; border: none;"> <tr> <td style="border: none; padding: 0 5px;">Male</td> <td style="border: none; padding: 0 5px;">Female</td> </tr> </table>	Male	Female
_____	_____	_____									
Month	Day	Year									
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)
-----------------------------	--------------------	---------------------------------

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)*								
	<table style="margin: auto; border: none;"> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none; font-size: small;">Month</td> <td style="border: none; font-size: small;">Day</td> <td style="border: none; font-size: small;">Year</td> </tr> </table>	_____	_____	_____	Month	Day	Year	<table style="margin: auto; border: none;"> <tr> <td style="border: none; padding: 0 5px;">Male</td> <td style="border: none; padding: 0 5px;">Female</td> </tr> </table>	Male	Female
_____	_____	_____								
Month	Day	Year								
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)

For Clinic/Office Use Only:

Date vax given:	Vax Type	Vax Manufacturer	Exp. Date/ Lot No	Dose	State Supplied	Preserv Free	Injection Site (Circle)	Route (Circle)	Date On VIS	Date VIS given
	TIV				Yes	Yes	Intranasal	R Arm L Arm		
	LAIV				No	No	Intramuscular Intradermal	R Leg L Leg		
	PPV23				Yes	N/A	Intramuscular	R Arm L Arm		
					No		Subcutaneous	R Leg L Leg		

Clinic Site Name: _____ MDPH Provider PIN#: _____

Clinic Address: _____

Signature of Vaccine Administrator: _____ Date: _____