

2016-2017 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
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

Insurance subscriber/policy holder, 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: * (If different from address above)		
City:*	State:*	Zip: *
		()
Patient Relationship to Subscriber: (Circle)* Spouse Child Other		

I give permission for vaccine administration, for my insurance company to be billed and entry/sharing of this information in the Massachusetts Immunization Information System (MIIS).

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

Please complete this section for children 18 years of age and younger:

Is Vaccine for Children (VFC) Program eligible:	
<input type="checkbox"/>	Is enrolled in Medicaid (includes MassHealth and HMOs etc. if enrolled through Medicaid)
<input type="checkbox"/>	Does not have health insurance
<input type="checkbox"/>	Is American Indian (Native American) or Alaska Native
Is not VFC-eligible:	
<input type="checkbox"/>	Has health insurance and is not American Indian (Native American) or Alaska Native

For Clinic/Office Use Only:

Provider (Check)	Provider Name/Address	Provider PIN #:
	Town of Grafton, Board of Health, 30 Providence Road, Grafton, MA 01519	14900
	Town of Holden, Board of Health, 1196 Main Street, Town Hall, Holden, MA 01520	22556
	Town of Leicester, Board of Health, 3 Washburn Square, Leicester, MA 01524-1333	14877
	Town of Shrewsbury, Board of Health, 100 Maple Avenue, Shrewsbury, MA 01545	11542
	City of Worcester, Division of Public Health, 25 Meade Street, Room 200, Worcester, MA 01610	11816

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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
	ccIV4	Seqirus (Flucelvax)	186111	05/31/2017	0.5	Yes	Yes	IM	R Arm L Arm R Leg L Leg	08/07/2015	
	ccIV4	Seqirus (Flucelvax)	185888	05/2017	0.5	No	Yes	IM	R Arm L Arm R Leg L Leg	08/07/2015	
	IIV4	Sanofi Pasteur (Fluzone)	UT5594RA	06/30/2017	0.25	Yes	Yes	IM	R Arm L Arm R Leg L Leg	08/07/2015	
	IIV4				0.5	Yes No	Yes No	IM	R Arm L Arm R Leg L Leg	08/07/2015	
	IIV4	Sanofi Pasteur (Fluzone)			0.5	No	No	IM	R Arm L Arm R Leg L Leg	08/07/2015	
	IIV4	Sanofi Pasteur (Fluzone)	UI625AA	06/30/2017	0.5	No	Yes	IM	R Arm L Arm R Leg L Leg	08/07/2015	
	IIV4	Sanofi Pasteur (Fluzone)	UI673AC	06/30/2017	0.5	No	No	IM	R Arm L Arm R Leg L Leg	08/07/2015	

IIV4 = Inactivated Influenza Vaccine, Quadrivalent
 ccIV4 = cell cultured inactivated influenza Vaccine, Quadrivalent

Signature of Vaccine Administrator:

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