Bedford Health Department

2022 - 2023 Insurance Information Form for Vaccination

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)* 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 Employed? 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:* / /	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		

All persons being vaccination must answer the subsequent questions numbered 1 – 5:	**Circle Yes or No**
1. Is this the first time the person to be vaccinated is receiving the influenza vaccine?	YES NO
2. Is the person to be vaccinated sick today with a fever?	YES NO
3. Does the person to be vaccinated have an allergy to a component of the influenza vaccine?	YES NO
4. Has the person to be vaccinated ever been diagnosed with Guillian-Barre syndrome?	YES NO
5. Are you pregnant?	YES NO
***If you are receiving FluMist, please answer the following questions:	
5. Has the person to be vaccinated ever had a serious reaction to the influenza vaccines in the past?	YES NO
6. If the person being vaccinated is less than 17 years old, is the person receiving aspirin therapy?	YES NO
7. Is the person being vaccinate currently taking antiviral agents?	YES NO
8. Has a provider determined the person to be vaccinated having a compromised immune system?	YES NO
9. Is the person being vaccinated have a history of asthma and/or wheezing?	YES NO

I give permission for my insurance company to be billed. I acknowledge that I (or my child) will receive the Flu Vaccine and I have received the Vaccine Information Sheet, dated August 6, 2021.

X _____ Date: _____

(Signature of patient, parent or legal guardian)

For children aged 18 years of age and younger: please check box next to any statements that are applicable:	
Is Vaccine for Children (VFC) Program eligible:	**Is not** VFC-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	☐ Has health insurance and is not American Indian(Native American) or Alaska Native

For Clinical Staff only:

Date of Service	Vaccine Name	Vaccine Mfgr.	Lot Number	Exp. Date	Dose (ml)	Inject. Route	Injection Site (Circle)	VIS Date	Date VIS Given	State Supplied	Preserv Free
						IM	R Arm L Arm R Leg L Leg	8/6/21		Y N	Y N

Provider Name: **Bedford Health Department** MDPH Provider PIN#: **10119**

Provider Address: **Town of Bedford- BOH 12 Mudge Way, Bedford, MA, 01730**

Signature of Vaccine Administrator: _____ Date: _____