# 2020 - 2021 Flu Insurance Information Form

## Town of Foxborough Public Health

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: (Check)* 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: * ____ ____ ____ Month Day Year | Sex: (Check)* Male ☐ Female ☐ |
|---|---|---|
| Subscriber's Street Address:* **(If different from address above)** | | |
| City:* | State:* | Zip: * | Phone:* ( ) |
| Patient Relationship to Subscriber: (Check)* Spouse ☐ | Child ☐ | Other ☐ |

**I give permission to receive the vaccine and for my insurance company to be billed.**

X _____ Date: _____

(Signature of patient, parent or legal guardian)

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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:**

| Date of Service | State Supplied (Circle) | Lot No | Exp Date | Date On VIS | Date VIS Given | Vax Type | Vax Mfgr | Dose | Preserv Free | Injection Route | Injection Site (Circle) | Signatuer of Vaccine Administrator |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Yes<br>No | | | | | IIV4<br>IIV4<br>IIV4-HD | Sanofi<br>Sequiris<br>Sanofi | .5mL<br>.5mL<br>.5mL | No<br>Yes | IM | R Arm<br>L Arm | |

Provider Name: **Foxborough Public Safety** MDPH Provider PIN# **42090**

Provider Address: 8 Chestnut Street, Foxborough, MA 02035