

2020-2021 Flu and Pneumo 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): *EXACTLY as on insurance card | Date of Birth (MM DD YYYY) * | Age:* | Sex (Male or Female):* |
| <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> |
| Street Address:* | | | |
| <input style="width: 95%;" type="text"/> | | | |
| City:* | ST:* | ZIP:* | 10-Digit Phone:* |
| <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> |

Insurance Information (may skip if insurance cards copied below*):

| | | |
|--|--|--|
| Name of Insurance Company:* | Member ID Number:* | Group ID Number (if available): |
| <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> |
| Medicare Number: | Is Medicare Primary? (Yes or No): | Is Subscriber Retired? (Yes or No): |
| <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> |

If person getting vaccinated is not the insurance subscriber/policy holder, please complete the following:

| | | |
|--|--|--|
| Subscriber's Name (Last, First, MI):* | Subscriber's DOB (MM DD YYYY):* | Sex (Male or Female):* |
| <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> |
| Subscriber's Street Address (if different from above):* | | |
| <input style="width: 95%;" type="text"/> | | |
| City:* | State:* | ZIP:* |
| <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> |
| 10-Digit Phone:* | | |
| <input style="width: 95%;" type="text"/> | | |
| Patient Relationship to Subscriber (Spouse, Child, or Other):* | | |
| <input style="width: 95%;" type="text"/> | | |

I give permission for my insurance company to be billed.

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

Attach Copies of ALL HEALTH INSURANCE CARDS Here:

Provider Name: TOWN OF ROWE
 MDPH Provider Pin: 14137
 Provider Address: 321 Zoar Road, Rowe, MA 01367