

2015-2016 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="width: 100%; border: none;"> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none; text-align: center;">Month</td> <td style="border: none; text-align: center;">Day</td> <td style="border: none; text-align: center;">Year</td> </tr> </table>	_____	_____	_____	Month	Day	Year		Male Female
_____	_____	_____							
Month	Day	Year							
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

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="width: 100%; border: none;"> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none; text-align: center;">Month</td> <td style="border: none; text-align: center;">Day</td> <td style="border: none; text-align: center;">Year</td> </tr> </table>	_____	_____	_____	Month	Day	Year	Male Female
_____	_____	_____						
Month	Day	Year						
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)

PLEASE READ:

You or your child's shot information will be entered into the Massachusetts Immunization Information System (MIIS) as required by Massachusetts General Laws Ch. 111, section 24M. The MIIS is a confidential, computerized statewide immunization tracking system. Immunization records may be shared with health care providers, school nurses, local boards of health and state agencies concerned with immunization. You can choose to restrict who may see your shot information in the MIIS at any time. For more information, contact Trish Parent, RN at the Upton Board of Health: 508-529-3110.

Provider Name: Town of Upton/Upton Health Services

MDPH Provider PIN # 11699

Provider Address: 1 Main Street, Upton, MA 01568

Mailing Address: 1 Main Street, Box 3, Upton, MA 01568

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For Clinic/Office Use Only:

Signature of Vaccine Administrator: _____

Date of Service	Vax Type	Vaccine Mfrgr	Lot No	Exp Date	Dose (mL)	State Supplied	Preserv Free	Injection Route	Injection Site (Circle)	Date On VIS	Date VIS Given
	IIV4	Sanofi Pasteur	UI440AA	06/30/16	0.5	Yes	No	IM	R Arm L Arm	8/7/15	
	LAIV4	Med-Immune	FJ2073	1/2/30/15	0.2	Yes	Yes	Intranasal	NA	08/7/15	
	IIV3	Novartis	1517501	6/2016	0.5	No	No	IM	R arm L arm	8/7/15	

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