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)*	Date of birth: * ____ ____ ____ Month Day Year	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 Retired? Yes No

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

Subscriber's Name: (Last, First, MI)*	Subscriber's Date of Birth: * ____ ____ ____ Month Day Year	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		

I give permission for my insurance company to be billed.

X _____ Date: _____

(Signature of patient, parent or legal guardian)

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***Place Photo Copy of All Insurance Cards Here:**

Provider Name: FRANKLIN REGIONAL COUNCIL OF GOVERNMENTS

MDPH Provider PIN#: 14294

Provider Address: 12 Olive Street, Suite 2, Greenfield MA 01301

COVID Self-Screen

ANSWER FOR ALL IN VEHICLE the DAY OF FLU CLINIC/EDS

Check ANY that APPLY

IF ANY CHECK YES – DO NOT ATTEND FLU CLINIC!

Today or within the last 24 hours have you experienced:	YES	NO
Fever or chills (100.4° Fahrenheit or higher, shaking chills)		
Cough (not due to other known cause, such as chronic cough)		
Shortness of breath/difficulty breathing		
Fatigue when in combination with other symptoms		
Muscle or body aches		
Headache when in combination with other symptoms		
New loss of taste or smell		
Sore throat		
Congestion or runny nose		
Nausea or vomiting		
Diarrhea		
Any other illness? not due to other known cause		
Have you had close contact to a person with active COVID in the last two weeks?		
Have you travelled to MA in the last two weeks from a place requiring self-quarantine?		

FLU VACCINE SCREEN ALL AGES	YES	NO	DON"T KNOW
Do you have a known allergy to any component of vaccine (e.g. egg) protein, thimerosal, latex packaging)?	___	___	___
Have you had a severe reaction to vaccine in your past?	___	___	___
Have you ever had Guillain-Barré Syndrome?	___	___	___

IS FLU MIST PREFERRED FOR YOUR CHILD (age 2 – 18 ONLY at this clinic)?

CIRCLE: YES NO

Attest for all in Vehicle Printed Name: Signature: _____