2020-2021 COVID-19 Vaccine Insurance Information Form [updated 2/1/2021]

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: * MA	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)

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:* MA	Zip: *	Phone:* ( )
Patient Relationship to Subscriber: (Circle)* Spouse Child Other		

In signing this form, I agree that:

Race: ____________________________ **Ethnicity**: __________________________

Email: ____

1. The information I provided is correct.
2. I have been provided the COVID-19 EUA Fact Sheet for Recipients and Caregivers which has information about the risks and benefits of the vaccine. I will be able to ask questions at the time I receive my immunization.
3. I have the legal authority to and give consent for me and any other person(s) I registered to be vaccinated with the vaccine(s) above.
4. I give permission for my insurance company to be billed for the costs of administering the vaccine(s). The government is paying for the vaccine itself and I will not be billed for that portion of the cost of my immunization.
5. I understand that as required by state law, all immunizations will be reported to the Department of Public Health Massachusetts Immunization Information System (MIIS). I can access the MIIS factsheet for Parents and Patients, at www.mass.gov/dph/miis, for information on the MIIS and what to do if I object to my or my family's data being shared with other providers in the MIIS.

X ____ Date: __________________

(Signature of patient, parent or legal guardian)

COVID-19 Vaccine	**Type of Vaccine***	**Date of Service**	**Dose** (mL)	**Route** (IM)	**Site** (RA,LA, RT,LT)	**Vaccine**			**EUA**	
						lot #	mfr.	Expir. Date	Date on EUA Factsheet	Date EUA Factsheet Given
Moderna COVID-19	Covid-19		0.5 ml	IM			Moderna		**12/2020**	

Signature of Vaccine Administrator: ____

Provider Name: ___Town of Mattapoisett, Public Health Nursing Office___ MDPH Provider PIN#: ___11074_____________

Provider Address: _____17 Barstow Street, Mattapoisett, MA 02739_____________________________________