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):*
Street Address:*					
City:*	ST:*	ZIP:*	10-Digit Phone:*		

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

Name of Insurance Company:*	Member ID Number:*	Group ID Number (if available):
Medicare Number:	Is Medicare Primary? (Yes or No):	Is Subscriber Retired? (Yes or No):

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):*
Subscriber's Street Address (if different from above):*				
City:*	State:*	ZIP:*	10-Digit Phone:*	
Patient Relationship to Subscriber (Spouse, Child, or Other):*				

I give permission for my insurance company to be billed.

X ____ Date: ________________

(Signature of patient, parent or legal guardian)

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Attach Copies of **ALL HEALTH INSURANCE CARDS** Here:

Provider Name: _FRANKLIN REGIONAL COUNCIL OF GOVERNMENTS__________________________

MDPH Provider PIN#: _14924_____

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