



Patient Name: _____ Last First MI			Date of Birth: _____
Mailing Address: _____			<input type="checkbox"/> Male <input type="checkbox"/> Female
City: _____	St: _____	Zip: _____	Phone: _____

**Only complete this section if the service is being billed to private health insurance**

**Name of Insurance Company:** \_\_\_\_\_

Group Number: \_\_\_\_\_

Insurance Billing Address: \_\_\_\_\_ Ins. Phone #: \_\_\_\_\_

Contract/Policy/ID #: \_\_\_\_\_

**Subscribers Information (Policy Holder of Insurance)**

Subscriber's Employer: \_\_\_\_\_

Subscriber's Relationship to Patient: \_\_\_\_\_

Self - **If Self, stop here**

Spouse  Child  Other **(Provide subscriber information below)**

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Sex:  Male  Female

**Is subscriber's address same as patient's?**  Yes  No, if no complete address below.

Address (Street): \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

**OFFICE USE ONLY**

**Use Private/Insurance Vaccine for everyone**

Bill Medicaid ID # \_\_\_\_\_ Health Plan (circle plan): UPHP FFS

Bill Business or Agency: \_\_\_\_\_ Prior arrangements must be made

Bill Health Insurance

Self Pay: (Circle payment)

\$40 - Flu (injectable) \$80 - High Dose Flu (≥ 65 years of age)

Cash \_\_\_\_\_ Check # \_\_\_\_\_ Cashier's Initials: \_\_\_\_\_

Check here if administration is documented in ECW  
If nurse did not enter this information into ECW, document below

**Vaccine Information:** Manufacturer: \_\_\_\_\_ Exp. Date: \_\_\_\_\_ Lot #: \_\_\_\_\_

**Administration Site:**  Injectable  L-Arm  R-Arm

**Signature/Title of Administrator:** \_\_\_\_\_ RN or LPN **Date Administered:** \_\_\_\_\_