



INSURANCE

NO INSURANCE

VISITING NURSE ASSOCIATION OF CAPE COD Member Cape Cod Healthcare

Flu Vaccine Immunization Record

PLEASE PRINT

PLEASE PRINT NAME AS IT APPEARS ON INSURANCE/MEDICARE CARD

Form with fields for Name (Last, First, MI), Birth date, Sex, Street address, age, Phone, TOWN OF RESIDENCE, City, State, Zip, Medicare number, Medicare PART B, Is Medicare primary insurance, All other Insurance information, ACCEPTED INSURANCES, Primary Insurance Information (If not Medicare), Insurance Name, Policy/ID number, Subscriber DOB, Subscriber Sex, Subscriber Name, Patient relationship to Subscriber, Allergies, and other medical history questions.

By signing below I am giving my permission for my Insurance to be billed and confirm that I have been given a copy and have read or have had explained to me the information on the flu vaccine information sheet (08/7/2015).

Signature of person to receive vaccine or that persons guardian Date

DO NOT WRITE BELOW THIS LINE

Injection site: RD LD Nurses name: Date administered: Vaccine Name: Fluzone Manufacturer: Sanofi Pasteur Lot #

Provider name: VNA of Cape Cod, Inc MDPH Provider PIN #

Clinic/office address: 255 Independence Drive, Hyannis MA 02601

Martha's Vineyard name/location of clinic

Your signature above authorizes the release of protected health information pertaining to treatment, payment and operations necessary to this billing process, physicians, medical facilities, contracting provider, and community agencies involved in your care, quality review activities (internal and external, including regulatory and accrediting organizations), and release of outcome information to the state and center for Medicare and Medicaid Services, and Joint commission on Accreditation of Health Care Organizations.