2013-2014 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 Employed? Yes No

If person getting vaccinated is not the subscriber, 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)

****

***Place Photo Copy of Card Here:**

Provider Name: Wayland Health Department MDPH Provider PIN#: 14726

Provider Address: 41 Cochituate Road Wayland, MA 01778____________________