# *LHD name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

PEF label

*DOCUMENT#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*HID/LOC/SITE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

# *LHD address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

# *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

# INFLUENZA VACCINE

**ADMINISTRATION RECORD**

**NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**ID/SOCIAL SECURITY#:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADDRESS:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *STREET CITY COUNTY STATE ZIP*

**BIRTHDATE:** \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_ **PHONE NUMBER:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*MONTH DAY YEAR*

**RACE:** (Check ONE or MORE) □ **(W)** White □ **(B)** Black or African American □ **(N)** American Indian or Alaska Native**\***

□ **(A)** Asian □ **(H)** Native Hawaiian or Other Pacific Islander **ETHNICITY:** Hispanic or Latino □Yes **or** □ No

**SEX:** (Check ONE) □Male □Female **How many in** **HOUSEHOLD:** \_\_\_ **Annual** **INCOME:** **$**\_\_\_\_\_\_\_ □**Income *NOT* Given**

DO YOU HAVE **MEDICAID**? □YES**\*** □NO IF YES, **MEDICAID NUMBER**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO YOU HAVE **MEDICARE**? □YES □NO IF YES, **MEDICARE NUMBER**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO YOU HAVE **HEALTH INSURANCE**? □YES □NO**\*** IF YES, **COMPANY NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Policy#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**YOU or YOUR CHILD ARE LESS THAN 19yrs old AND HAVE HEALTH INSURANCE COVERAGE:**

□ **YES,** the insurance does cover vaccines; □ **NO,** the insurance does not cover vaccines **\*** ***\* VFC eligible***

The health department may keep this record in a medical file. They will record what vaccine was given, when the vaccine was given, the name of the company that made the vaccine, the vaccine’s special lot number, the vaccine injection site, the signature and title of the person who gave the vaccine, and the address where the vaccine was given.

**I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me or to the person named above for whom I am authorized to make this request.**

## I request that payment of authorized medical insurance benefits be made to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ on my behalf or behalf of my child, for services received. I also authorize the local health department to release medical information to Medicare, Other Third Payors (insurance carriers, Medicaid, etc.) and their agents to determine payment for services. I am aware that should Medicare refuse payment for this service, I will be responsible for the cost. If I am covered by a billable private insurance, I am aware that I may be responsible for some additional charges not covered by my plan.

**X**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Signature of person to receive vaccine or person authorized to make the request (parent or legal guardian/representative)***

**“I have read or have had explained to me the information sheet:**

**( X ) *Influenza (Flu) Vaccine****)* ***(Inactivated or Recombinant):, “What You Need To Know”* *(VIS Dated 08/06/21)***

## FOR HEALTH DEPARTMENT USE ONLY VFC: YES\* NO FFC: YES NO

**Vaccine Manufacturer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Vaccine Lot Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Injection Site:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature and Title of Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Provider# :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NOTES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ICD Code:**  **Z23.** Encounter for immunization

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **√** | **INFLUENZA (VFC under 19yrs *OR*  Medicaid covered)** | | | **√** | **INFLUENZA (NON-VFC OR Medicare, Insurance)** |
|  | **90660** (LAIV3) intranasal, FluMist, ages 2yrs-49yrs | | |  | **90660NV** (LAIV3) intranasal, FluMist, ages 2yrs-49yrs |
|  | **90656**  (IIV3) 0.5 ml 6 Months and older | | |  | **90657NV** (IIV3) 0.25 ml dose 6 to 36 months |
|  | **90658** (IIV3) 0.5 ml dose 3 years & older | | |  | **90658NV** (IIV3) 0.5 ml dose, 3 years & older |
|  | **90661**  ((ccIIV3, 0.5 ml 6 months and older | | |  | **90661NV** (ccIIV3), 0.5 ml 6 months and older |
|  |  | | |  | **90673NV**  (RIV3), 0.5 ml 18 years & older |
|  |  | | |  |  |
|  |  | | |  |  |
|  | **80000 Unspecified Procedure** | | |  |  |
| **ADMINISTRATION** | | | | **Patients 65 & older Vaccines:** | |
|  | G0008 Adm. of Influenza Vaccine | | |  | 90662 (IIV3-HD) HIGH DOSE |  |
|  | 90471 Adm. of Influenza INJ., Not-Component |  | 90473 Intranasal |  | 90653 ((aIIV3) 0.5 ml |  |
|  | 90460 VFC/not VFC, **by component** | | |  |  |

***Self Pay Only***: Amount Collected $\_\_\_\_\_\_\_\_\_\_\_\_**Patient Signature X**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_