# Flu Immunization 2018-2019

HOME CARE SERVICES
MICHIGAN VISITING CARE
MICHIGAN MEDICINE
UNIVERSITY OF MICHIGAN

**Tax ID: 38-6006309**
**Quadrivalent Vaccine Code: 90686 / 90688**
**High Dose Vaccine Code: 90662**
**Admin Code: G0008 / 90471 ICD: Z23**

## Please Print Clearly

**MRN #** _____

LEGAL NAME

Last: _____ Other Last Name Used: _____ First: _____ MI: _____

Weight: _____lbs Date of Birth: _____/_____/_____ Age: _____ Gender: Male / Female

Phone Number: (_____) _____-_____ Address: _____ City: _____

County _____ State: _____ Zip Code: _____ *Email Address: _____

**I consent to being contacted through email for satisfaction survey purposes, education, and for information about future flu clinics.*

Name of responsible party for patients under age 18:

Last: _____ First: _____ MI: _____

***Please circle your answer on the right side of the page.***

| | | | |
|---|---|---|---|
| 1. | Are you sick today or are you running a temperature of 101.5° F or over? | No | Yes |
| 2. | Did you begin taking an antibiotic yesterday or today? | No | Yes |
| 3. | Are you allergic to eggs, latex or thimerosal? | No | Yes |
| 4. | Are you allergic to Benadryl or Epinephrine? | No | Yes |
| 5. | Have you ever been diagnosed with Guillain-Barré Syndrome? | No | Yes |
| 6. | Do you take blood thinners (such as Coumadin or Warfarin)? | No | Yes |
| 7. | Have you had another immunization in the last 14 days? | No | Yes |
| 8. | Have you ever had an allergic reaction or problem after a vaccination? | No | Yes |
| 9. | Has it been three or more years since your last flu shot? | No | Yes |
| 10. | Have you ever been seen by a University of Michigan physician (including in the ER)? | No | Yes |

**PATIENT CONSENT**

I have read the information sheet about influenza (the flu) and influenza vaccine. I have had a chance to ask questions which were answered to my satisfaction. The information I have provided above is correct and true to the best of my knowledge. I understand the benefits and risks of influenza vaccination and request that the vaccine be given to me or to the person listed below for whom I am authorized to make this request.

I understand that MVC can only bill certain insurances and that if I have an insurance MVC cannot bill, I am required to make payment to MVC at the time that services are provided. MVC will provide me with a receipt that contains information necessary to submit a claim to my insurance company in order to seek reimbursement directly. It is my responsibility to work with my insurance company to resolve any issues related to reimbursement. I understand that MVC cannot guarantee insurance reimbursement and that if my insurance company provides reimbursement it may only reimburse a portion of what I've paid today. I understand that I am responsible for insurance copays and deductables. I acknowledge that a copy of the Notice of Privacy Practices was offered to me.

_____ Date_____
Signature of person to receive vaccine.

_____
Signature of person authorized for patient listed above **(if under 18 yrs of age or physically unable)**

## To Be Completed by MVC CLINIC STAFF

**Immunization site: IM** ❑ Deltoid ❑ Thigh ❑ Left ❑ Right

**Vaccine Type:** ❑ MDV ❑ Prefilled ❑ High Dose

**Manufacturer:** ❑ GSK ❑ Sanofi Fluzone ❑ Other _____

**DOSAGE:** ❑ 0.5

**Lot Number:** _____ **Nurse:** _____

### INSURANCES ACCEPTED (Must Be Patient's Primary Coverage)

❑ Aetna ❑ Aetna Medicare Advantage ❑ Alliance Health and Life ❑ Blue Care Network
❑ BCBS ❑ Blue Cross Complete ❑ Cigna ❑ HAP ❑ HAP Senior Plus
❑ PHP ❑ Priority Health Medicare Advantage ❑ Priority Health HMO or PPO
❑ Medicare Part B ❑ BCBSM Medicare Plus Blue PPO ❑ BCN Advantage

**Name of Primary Insurance Holder:** ❑ Same As Patient *(if different please enter name below)*

Last: _____ First: _____ DOB: ____/____/_____

**Patient's Relationship To Insurance Holder:** ❑ Child ❑ Spouse

**Insurance ID / Contract number:** _____

**Insurance GROUP number:** _____

### PRIVATE PAY

Prompt Pay Fee:_____

❑ **Cash**

❑ **Check #**_____

❑ **Credit Card**

❑ **MVC Voucher**

❑ **Corporate Pay**

❑ **UMHS Employee ID#**_____

❑ **UM Student ID#**_____

❑ Other_____

White copy — MVC **Pink copy — Patient**