2025-2026 Flu and COVID 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. **PLEASE BRING ALL ACTIVE INSURANCE CARDS TO CLINIC**

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 Retired? Yes No

If person getting vaccinated is not the insurance subscriber/policy holder, 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)

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Is a Flu Dose desired?

____Yes ____No

Please circle preference: High Dose or Standard Dose

Is a COVID Dose desired? (We will have Moderna, when available)

____Yes ____No

Please attach a Photo Copy of All Insurance Cards

Provider Name: FRANKLIN REGIONAL COUNCIL OF GOVERNMENTS MDPH Provider PIN#: 14924

Provider Address: 12 OLIVE ST., STE 2, GREENFIELD, MA 01301