GetA*FluShot*.com

A Professional Health Care LLC Company, Established 1989
Community Immunization Provider since 1991

Insurance Claim Form and Consent Influenza Immunization

Check Primary insurance plan: ☐ **Medicare Part B** ☐ **Regence BlueCross BlueShield** ☐ **Premera**
☐ **LifeWise** ☐ **Providence Health Plan** ☐ **MODA Health** **AETNA** ☐ **Kaiser Permanente**
☐ **Soundpath Health** ☐ **PacificSource Medicare** ☐ **PacificSource** (*not Community Solutions*) ☐ **Asuris NW Health**
☐ **Uniform Medical Plan** ☐ **Samaritan** ☐ **Sterling Option Medicare Advantage** ☐ _____

Patient Information (PLEASE PRINT)

Last Name: First Name: (middle initial) MI:

Primary Insurance ID #

(Secondary Insurance)
Insurance Plan Name ID Number:

(Month/Day/Year)
Date of Birth: _____ Sex: ☐F ☐M

Mailing Address:

City: State: ZIP Code:

Phone #: (_____) _____ - _____

Have you ever had a flu vaccination before? ☐Yes ☐No ☐Unsure Are you allergic to eggs? ☐Yes ☐No
Have you ever had a severe reaction to a flu shot? ☐Yes ☐No Are you allergic to latex? ☐Yes ☐No
Do you have a history of Guillain-Barre Syndrome? ☐Yes ☐No If female, are you pregnant ☐Yes ☐No

I have read/had explained to me the Vaccine Information Statement about influenza and influenza vaccine. I have had a chance to ask questions and had them 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 agree that neither GetAFluShot.com nor its sponsor or host site shall have any responsibility or liability if I contract influenza or other respiratory diseases, or suffer any other adverse reaction, following administration of the flu shot. I understand that I am responsible for payment for the vaccine if my insurance carrier denies payment.

X Signature of responsible person: _____ **Relationship:** _____ **Date:** _____

Community Provider/Health Plan Use Only

Clinic Use Only

Clinic Location: _____

Date of Vaccination: _____

Mfg/Lot #: _____ Expiration Date: _____

Nurse's Initials: _____ Site of Injection: **L R Deltoid**

Please remit to: GetA*FluShot*.com

(503) 258-9800 **(877) 358-7468**
(503) 258-8311 fax

GAFS 08/12

8/1/03