MCIR Seasonal Influenza/H1N1 Scan Form (SF7)

Mail To:

Personal Information (Print clearly in capital letters and use black ink)

Last

First

Date of Birth: (mm-dd-yyyy) - -

County of Residence (MI Only) numeric code

Sex: ○ Male ○ Female

Street

City State

ZIP Code Phone ( ) -

Eligibility/Insurance Information (Record and sign below)

○ Uninsured ○ Under Insured ○ Native American ○ Medicare Part B-HICN #

○ Medicaid ***(Specify the plan and Medicaid #)***

Medicaid Plan:_____

#

[ ]Employer Pay *Name*:

[ ]Self Pay *Amount* $

○ Insurance ***(Specify type and attach a copy of card)***

Name of Insurance:

Policy/Contract #:

[ ]Tribe Name:

[ ]Cash [ ]Check Staff Initials:

Consent & Assignment of Benefits Agreement: I request that the noted Healthcare Provider administer the vaccination/medication and I further request that payment of authorized benefits be made to this Provider on behalf of any services furnished to me by this Provider. I understand that I am responsible for all applicable co-payments in accordance with my health plan. I also understand if in the event my health plan does not cover this service I may be responsible for payment to the Provider. I authorize the noted Healthcare Provider to release any medical information needed to determine these benefits for related services.

Signature: Person to receive vaccine or person authorized to make request;If under 18-parent or guardian

X

Date:

Clinic Use Only (Please do not complete this section)

Provider ID U

Clinic Name/Address

Date Vaccine(s) Administered
Date VIS Given: (MM-DD-YYYY) - -

Patient Screening Questionaire Completed? Yes No

Seasonal Influenza ○ **Live (Flu Mist)** ○ **Inactivated**

Manufacturer: **Lot Number:** Date on VIS

Site	Route	Dosage
RUA LUA RT LT Nasal	IM SC PO IN	

H1N1 Vaccine Code:

Manufacturer: **Lot Number:** Date on VIS

Site	Route	Dosage
RUA LUA RT LT Nasal	IM SC PO	

Vaccine Administrator Signature/Title

X

Revision Date Sept. 2009

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