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

PEF label

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

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

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

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

# COVID-19 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***

## 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)***

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, and all were answered to my satisfaction. I understand the benefits/risks of the COVID-19 vaccine, the COVID-19 vaccine dosing intervals and attest that I meet all eligibility requirements to receive the requested COVID-19 vaccine. I give my informed consent for the vaccine be given to me or to the person named above for whom I am authorized to make this request.**

**Patient Signature X**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

## FOR HEALTH DEPARTMENT USE ONLY

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

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

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

|  |  |  |  |
| --- | --- | --- | --- |
| **√** | **COVID-19 VACCINE:(VFC under 19yrs *OR*  Medicaid covered)** | **√** | **COVID-19 NON-VFC VACCINE: (NON-VFC OR Medicare, Insurance)** |
|  | 91318 – Pfizer-SARSCOV2-VAC (Yellow cap) 0.3 mL IM |  | 91318NV–Pfizer-SARSCOV2-VAC (Yellow cap) 0.3mL IM |
|  | 91319 – Pfizer-SARSCOV2-VAC (Blue cap) 0.3 mL IM |  | 91319NV–Pfizer-SARSCOV2-VAC (Blue cap) 0.3 mL IM |
|  | 91320 – Pfizer-SARSCOV2-VAC (Gray cap) 0.3 mL IM |  | 91320NV–Pfizer-SARSCOV2-VAC (Gray cap) 0.3 mL IM |
|  | 91321 – Moderna – SARSCOV2-VAC 0.25 mL IM |  | 91321NV – Moderna – SARSCOV2-VAC 0.25mL IM |
|  | 91322 – Moderna – SARSCOV2-VAC 0.5mL IM |  | 91322NV– Moderna – SARSCOV2-VAC 0.5mL IM |
| **√** | **ADMINISTRATION:** |  |  |
|  | 90480 – Administration of SARSCOV2 VACC 1 Dose |  |  |
|  | **80000 Unspecified Procedure** |  |  |