Seasonal Influenza Vaccine 2010-2011
Adult Vaccine Administration Record

MAHP/Masspro Reimbursement Program

Information about the person to receive vaccine (please print):

Name: (Last, First, MI)	**Birth date:**	**Age:**	**Sex:** M☐ F☐
Street address:			
City:	**State:**	**Zip:**	**Phone:** ( )

If you have a membership card from one of these plans, write in the card number:

AARP MedicareComplete (SecureHorizons/UnitedHealthcare)	#
Evercare Plan MP/PPO (UnitedHealthCare)	#
Evercare Senior Care Options (UnitedHealthcare)	#
Fallon Senior Plan (Fallon Community Health Plan)	#8
First Seniority Freedom (Harvard Pilgrim Health Care)	# 9 _ _ _ _ – _ _ _ _ _ _ _ _ _ – _ _
HNE Medicare Advantage Plans (Health New England)	#9
Medicare HMO Blue (Blue Cross Blue Shield of MA)	# XXC
Medicare PPO Blue (Blue Cross Blue Shield of MA)	# XXU
NaviCare (Fallon Community Health Plan)	#8
Senior Whole Health	# 1 _ _ _ _ _
Tufts Health Plan Medicare Preferred (Tufts Health Plan)	# S _ _ _ _ _ _ _ _

Medicare Card Number	#

I give permission to bill my insurance company.
(Signature of person to receive vaccine or that person's guardian)

X _____ **Date** _____

For Clinic/Office Use:

Vaccine name: _____ Date vaccine administered: _____

Injection site: _____ Date VIS given: _____ Date on VIS: _____

Vaccine manufacturer: _____ Vaccine lot number: _____

Name and title of vaccine administrator: _____

Clinic/office address: _____