Front Range FLU SHOTS LLC
ON-SITE IMMUNIZATIONS

CONSENT FOR TREATMENT INFLUENZA Immunization

✓ Please make checks payable to Front Range Flu Shots, LLC *or* FRFS

Please print. Use legal name or name as it appears on insurance card of person getting vaccinated.

Last Name	First Name	Middle Initial	Birthdate (MM - DD - YYYY)	Age	Gender
			/ /		❑ Male ❑Female ❑Other

Home Address	Apt #	City	State	Zip	Phone#: ❑ Home or ❑ Cell

This section is to be completed only if we are billing your insurance. Co-payment may apply.

We do NOT ACCEPT Kaiser or Medicaid. Exclusive provider organizations (EPOs), types of private individual and family health insurance plans, are NOT ACCEPTED including, but not limited to, Cigna Connect, Cigna Freedom, and Humana HMOX.

UnitedHealthcare CORE, Charter, Navigate, Centura, Colorado Doctors Plan or any short-term policies are NOT ACCEPTED.

- ❑ Aetna ❑Cofinity ❑Meritain: Cofinity & Meritain Insurance Ph # _____ Claims Address _____
- ❑ Cigna
- ❑ HealthPartners
- ❑ Humana
- ❑ Medicare Part B is my Primary Insurance Plan or ❑Railroad Medicare is my Primary Insurance Plan
- ❑ Medicare Advantage Plan: _____ ❑ Anthem Medicare Preferred (PPO) Colorado PERA
- ❑ Rocky Mountain Health Plans
- ❑ UMR Insurance Phone # _____ Claims Address _____
- ❑ UnitedHealthcare

Insurance Member ID#	Group Plan or Payer ID	Patient Relationship to Primary Insured
		❑ Self ❑ Spouse* ❑ Child* ❑ Other*

*Spouse, Child or Other provide Primary Insured's Name	* Primary's Member ID	*Primary's Birthdate (MM/DD/YYYY) and Gender
		/ / ❑Male ❑Female ❑Other

Answer the following questions, sign and date below:

1. Do you currently have a fever, chills, or moderate or severe acute illness with or without fever? Temp: _____ Yes No
2. Do you have a cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, or diarrhea? Yes No
3. Have you ever had a flu immunization before? Yes No
4. Do you have a history of hypersensitivity (allergy) to chicken eggs or egg protein? Yes No
5. Have you ever had an adverse or allergic reaction to any component of the vaccine, including thimerosal? Yes No
6. Do you have a history of Guillain-Barre Syndrome (a severe paralytic disease, also called GBS)? Yes No
7. Have you ever had a bad reaction to any other vaccine? Yes No

Explain any adverse or allergic reactions: _____

★ The current applicable CDC *Influenza Vaccine Information Statement* has been provided to me. I have read or have had explained to me the information. I have had a chance to ask questions and, if any, they were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and I ask that the vaccine be given to me or to the person named on this form for whom I am authorized to make this request. I agree that Front Range Flu Shots, LLC (FRFS) shall have no responsibility or liability if I or the named person contract influenza or any other respiratory diseases or suffer any adverse reaction following administration of the influenza vaccine.

★ **Notice of Privacy Practices:** The information on the consent form is the only information FRFS has about you. Information may be used and disclosed for insurance reimbursement purposes and to provide emergency treatment if an emergency develops as a result of this immunization. Upon request, a receipt or copy of this form can be sent to you or an authorized person via mail, email, or fax. Any other release would require your authorization. You can review and request a copy of *Notice of FRFS's Privacy Practices*.

★ I understand that I am responsible for payment to FRFS if vaccination is not fully covered by insurance company and there is a $30 fee for returned checks.

Signature of Responsible Person: _____ **Date:** _____

Insurance Coding and Billing Information for Influenza Vaccination

Front Range Flu Shots, LLC • 7421 S. Curtice Ct., Littleton, CO 80120
Phone 303-797-3396 • Fax 303-797-3397 • Federal Tax ID: 743077363

Influenza Type	Quadrivalent Shot	Quadrivalent Flucelvax Shot	Fluzone High Dose Shot	Seqirus Fluad Shot	Amount Paid
Service Location:	60	60	60	60	
Diagnosis Code: ICD-10	Z23	Z23	Z23	Z23	
Vaccine Admin. Code:	90471	90471	G0008	G0008	
Vaccine Code:	❑ 90686 (S) ❑ 90688 (M)	❑ 90674 (S) ❑ 90756 (M)	90662	90694	$_____

Injection site (0.50mL)
☐ L Deltoid
☐ R Deltoid

VIS Provided: Inactivated Influenza Vaccine 08/15/2019

RN _____ Date _____
Mfg
Lot #
Exp. Date

Clinic Location: _____ Invoice _____

Aetna CIGNA Cofinity DCSD Health Partners Humana MC MEDADV / PERA Meritain RMHC UMR UHC Comp Cash Check # _____

Credit Card Charged at Clinic ☐ Yes ☐ No Email: Name No# Exp. Date Security Code Zip Code 8.6.2020