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. You are responsible for payment if vaccination is not covered by insurance.

Kaiser, Medicaid, American Postal Workers Union Health Plan (APWU), and Exclusive Provider Organizations (EPOs), types of private individual and family health insurance plans, including, but not limited to, Cigna Connect, Cigna Freedom, and Humana HMOX are NOT ACCEPTED.
UnitedHealthcare CORE, Charter, Navigate, Centura, Colorado Doctors Plan, DU Plans or any short-term policies are NOT ACCEPTED.

- ❑ 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
- ❑ Aetna ❑Cofinity ❑Meritain: Cofinity & Meritain Insurance Ph # ________________ Claims Address ____________________________
- ❑ Anthem BCBS
- ❑ Cigna
- ❑ HealthPartners
- ❑ Humana
- ❑ Rocky Mountain Health Plans
- ❑ UMR Insurance Phone # ____________________ Claims Address ____
- ❑ UnitedHealthcare: Plan _________________

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:

	Question		
1.	Have you ever had a flu immunization before?	Yes	No
2.	Do you currently have a fever, chills, or moderate or severe acute illness with or without fever?	Yes	No
3.	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
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 ____. T_________

- ★ 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*.
- ★ **CIIS Notification Information:** You/your child's vaccine information may be reported to the Colorado Immunization Information System (CIIS), a confidential, secure, statewide immunization registry. You may choose to exclude you/your child's information from CIIS at any time. Contact FRFS for further information.
- ★ 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 • NPI: 1598801615

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 08/06/2021

RN ____________________ Date ____________

Mfg

Lot #

Exp. Date

Clinic Location: _________________________ Invoice__________________________

(8.13.21)

❑Credit Card #_________ Charged at Clinic ☐ Yes ☐ No Email: Name No# Exp. Date Security Code Zip ❑Comp ❑Cash ❑Check #__________