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 name and gender as it appears on insurance card of person getting vaccinated.

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

Home Address Street Apt. # City State Zip Code Phone# ❑ Home or ❑ Cell

**Insurance Billing. Answer questions and provide all insurance Member ID#'s** You are responsible for payment if vaccination is not covered by insurance. Benefits are subject to all contract limitations and the member's eligibility status. INSURANCES NOT ACCEPTED include but are not limited to: Kaiser, Medicaid, Cigna True Choice Medicare, Devoted Health Medicare Advantage, Humana HMOX, UHC Centura, Freedom, DU Plans.

❑ Medicare Advantage Plan Name _____ ❑HMO ❑PPO Member ID _____

Provider Services / Customer Service Phone Number listed on back of card _____

❑ Medicare Part B # _____ ❑ Railroad Medicare # _____

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❑ Yes ❑ No Permission to email for insurance or medical purposes? Email address: _____

❑ Yes ❑ No Permission to leave a voice or text message? If yes, specify: ❑ Home ❑ Cell ❑ Voice Message ❑ Text Message

❑ Aetna ☐ First Health ☐ Meritain ❑ Cigna ❑ HealthPartners ❑ Humana ❑ UMR* ❑ UnitedHealthcare (UHC)*

❑ Anthem BCBS Deductible, copayment, & co-insurance may apply to any plan. Verification of benefits or coverage is not a guarantee of eligibility or payment. Actual payment is based on the terms and conditions of the plan and all claims are subject to review upon submission._____

| Insurance Member ID # | Group # | *Payer ID # UMR & UHC only. | *Insurance Plan Name UHC policies only. | Phone # Provider Services listed on back of card |
|---|---|---|---|---|
| | | | | |

❑ Self ❑Spouse ❑ Child ❑ Other ☐ Male ☐ Female

| Patient Relationship to Policy Holder If you are a Spouse, Child, or Other provide: | Policy Holder Name For Spouse, Child, or Other | Policy Holder Member ID For Spouse, Child, or Other | Policy Holder Birthdate (MM/DD/YYYY) Gender For Spouse, Child, or Other |
|---|---|---|---|
| | | | |

**Answer the following questions, sign, and date below:**

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. Have you ever had an adverse or allergic reaction to any component of the vaccine, including thimerosal? Yes No
5. Do you have a history of Guillain-Barre Syndrome (a severe paralytic disease, also called GBS)? Yes No
6. 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.*

★ **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 | Trivalent Shot | Trivalent 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: | ❑ 90656 (S) ❑ 90658 (M) | ❑ 90661 | 90662 | 90653 | $_____ |

Injection site 0.5mL
☐ L Deltoid
☐ R Deltoid

VIS Provided: Inactivated Influenza Vaccine 1/31/2025

RN _____ Date _____
Mfg
Lot #
Exp. Date

Clinic Location: _____ 8.3.25 Invoice_____

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