



A Professional Health Care LLC Company, Established 1989
Community Immunization Provider since 1991

WA State Employee Insurance Claim Form and Consent: Influenza Immunization UMP & Group Health accepted

Please check insurance plan: Uniform Medical Plan of Washington Group Health Medicare Part B
For use by Washington State employees & covered dependants Group Health members under non-state plans may not be covered for flu vaccinations

Patient Information (PLEASE PRINT)

Last Name: _____ First Name: _____ (middle initial) MI: _____

Insurance ID#
Member ID Number:
(Month/Day/Year)

Date of Birth: _____ Sex: F M

Mailing Address:

City: _____ State: _____ ZIP Code: _____

Phone #: (_____) _____ - _____

Insured's ID Number (if different from above): _____ Relationship to Patient: _____

Have you ever had a severe reaction to a flu shot? Yes No Are you allergic to eggs? Yes No
Do you have a history of Guillain-Barre Syndrome? Yes No If female, are you pregnant Yes No
Are you allergic to latex? Yes No

I have read/had explained to me the Vaccine Information Statement about influenza and influenza vaccine. I have had a chance to ask questions and had them answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me or to the person named above for whom I am authorized to make this request. I agree that neither GetAFluShot.com nor its sponsor or host site shall have any responsibility or liability if I contract influenza or other respiratory diseases, or suffer any other adverse reaction, following administration of the flu shot. I understand that I am responsible for payment for the vaccine if my insurance carrier denies payment.

X Signature of responsible person: _____ Relationship: _____ Date: _____

Community Provider/Health Plan Use Only

Federal Tax ID: 91-1754065 Service Location: 60
NPI # 1528244282
CPT Code (vaccine): 90658 CPT Code (admin): 90471

Diagnosis Code: V04.81

Charge: _____

Clinic Use Only

Clinic Location: _____

Date of Vaccination: _____

Mfg/Lot #: _____ Expiration Date: _____

Nurse's Initials: _____ Site of Injection: **L R Deltoid**

Please remit to: **GetAFluShot.com**
135 SE 102nd Ave
Portland, OR 97216

(503) 258-9800 (877) 358-7468
(503) 258-8311 fax