Insurance Information required at time of COVID Immunization Administration

For some insurance plans this will be processed by your prescription plan, for others it will be covered by your medical plan. Both will be collected at this time to ensure accurate process completion.

Your Name: First _____ Last _____

Date of Birth _____ Last 4 digits of SSN _____

If over 65 or on Medicare your Medicare part A/B # _____

Prescription Plan information:

Name of Plan _____

Bin # _____

PCN # _____

Group # _____

ID # _____

Relationship circle one: Primary Spouse Child

If not Primary, please provide primary insured's name: _____

Medical Plan information:

Name of Plan _____

Group # _____

ID # _____

Processor control # if on card _____

Relationship circle one: Primary Spouse Child

If not Primary, please provide primary insured's name: _____