NORTH HALEDON FLU CLINC

TUESDAY OCTOBER 16, 2018

MUNICIPAL BUILDING

103 OVERLOOK AVENUE

4PM- 6:30PM

PLEASE BRING MEDICARE CARDS AND INSURANCE CARDS

PAPERS CAN BE PICKED UP AT MUNICIPAL BUILDING,
LIBRARY OR OFF OUR WEB SITE.

CITY OF PATERSON DIVISION OF HEALTH
FLU ASSESSMENT/CONSENT FORM

Name (Please Print) _____ Date of Birth _____ Age _____

Address _____ City _____ State _____ Zip _____

I authorize medicaid/medicare payment of medical benefits to the Paterson Division of Health, for services described below, for services rendered to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for related services.

I have read the information about Influenza and Pneumococcal vaccine and I have had a chance to ask questions. I understand the benefits and risks of the vaccination and request that the vaccines be given to me or person named above for whom I am authorized to sign.

Medicaid/Medicare #: _____

Signature (Person receiving vaccine or Guardian) _____ Phone _____

For Clinic Use
Flu

Name of Clinic _____

Date of Vaccination _____

Manufacture: GSK
Lot # YZ7TR
Exp: 6-30-2019

High Dose
Manufacture:SP
Lot # UJ004ab
Exp: 3/30/2019

Site of Injection _____

Allergies Yes ☐ No ☐

Chronic Disease Yes ☐ No ☐

Administered By _____

Medicaid: ☐ Medicare: ☐ Pay: ☐
Non Pay: ☐

Private Physician:

Name: _____

Phone: _____

FLU VACCINE

ASSESSMENT QUESTIONS	YES	NO	DON'T KNOW
you have a history of allergy to this vaccine and or its components?			
you allergic to eggs?			
you allergic to chicken feathers?			
you allergic to chicken?			
ve you suffered from Gullain-Barre Syndrome?			
you have Multiple Sclerosis or Hodgkins disease?			
you have any recurring neurological ailments?			
you receive immuno-suppressive drugs?			
you currently sick with a cold, fever or respiratory infection?			
e you received other vaccines in the past month? Name of vaccine received.			
you Pregnant?			
e you been told by a physician that you should NOT receive this vaccine?			

gado (7/15)

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX M F	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other	7. INSURED'S ADDRESS (No., Street)
CITY STATE	8. RESERVED FOR NUCC USE	CITY STATE
ZIP CODE TELEPHONE (Include Area Code)		ZIP CODE TELEPHONE (Include Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER NONE
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [X] NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES [X] NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES [X] NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. A. B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC
226002200 [ ] [X]		[X] YES [ ] NO	$	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
SIGNED DATE	PATERSON DIVISION OF HEALTH 176 BROADWAY PATERSON NJ 07505-1115 a. 1801001300 b.	(973) 3211277 PATERSON DIVISION OF HEALTH 176 BROADWAY PATERSON NJ 07505-1115 a. 1801001300 b.