INSURANCE ATTESTATION FORM

Date: _____
Patient Name (First & Last): _____ Phone Number: _____

Section A: Insurance Coverage Information

Please provide **all applicable** insurance information below.

Note: For active coverage, but unsure of the insurance information, provide the last 4 digits of your Social Security Number. (Last 4 digits of your SSN)- _____

1. ***Pharmacy Insurance Information:***

   Insurance Carrier: _____ Patient ID:_____

   Primary Cardholder (Y/N) _____ Dependent Number_____

   BIN:_____ PCN:_____ Group:_____

2. ***Medical Insurance Information:***

   Insurance Carrier: _____ Patient ID:_____

   Group: _____ Payer ID:_____

3. ***Medicare Insurance Information (RED, WHITE & BLUE CARD):***

   Name (as it appears on the card): _____

   Medicare ID #: _____

Section B: Long Term Care Facility (LTCF) Clinic - *Place of Service Confirmation*

Complete the section ONLY if you are receiving an immunization at a LTCF.

Place a check next to the administration setting below in which you are receiving your vaccination to ensure we correctly file the claim for your vaccination service.

☐Communal Setting at the Long Term Care Facility **(no reason or signature required)**

☐Patient Room **(reason and signature required below)**

- I confirm that the vaccination service was provided in my patient room as indicated below.

Reason: _____

Patient Signature: _____