ASCENSION

Ascension Illinois Influenza Vaccination Billing Form

Recipient Information *(Please Print Clearly)*

Last Name: _____First Name: _____ Age: _____ Date of Birth: _____

Home Address: _____City: _____State: _____ Zip Code: _____

Phone Number: _____ Gender: ❑ Male ❑ Female ❑ Other Preferred Language: _____

Race: ❑Hispanic or Latino ❑non-Hispanic or Latino ❑unknown ❑prefer not to say

Ethnicity: ❑American Indian/Alaska Native ❑Asian ❑Black/African American ❑Native Hawaiian/Pacific Islander ❑White

For Office Use Only

For Self-Pay Only

Total Amount $_____ ☐ Cash ☐ Check #_____

☐ Client is paying for the following person(s):_____

For Waiver Only

☐ Client is unable to pay.

I am unable to afford the cost of a flu vaccination at this time and am requesting that it be given to me at no charge.

_____ _____

Client signature Signature and Title of Health Professional

For Medicare Patients Only

Medicare Part B number exactly as it appears on the Medicare Card

My signature below indicates my approval for Ascension Illinois to bill Medicare for the cost of today's flu vaccine and administration. I understand that Medicare Part B provides coverage for one flu vaccination and administration per year.

_____ _____

Signature of person to receive vaccine or person authorized to make request Date