



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: _____

Email: _____ Gender: ☐ Male ☐ Female ☐ Other Language Spoken at Home: _____

Ethnicity: ☐ Hispanic or Latino ☐ Mexican ☐ Puerto Rican ☐ Cuban ☐ Other _____ ☐ Not-Hispanic or Latino

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other _____

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

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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