

## **Ascension Illinois Influenza Vaccination Billing Form**

## **Recipient Information** (Please Print Clearly) Last Name: \_\_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Home Address: \_\_\_\_\_ City: \_\_\_\_ State: \_\_\_ Zip Code: \_\_\_\_ Email: \_\_\_\_\_ Gender: $\square$ Male $\square$ Female $\square$ 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 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