

DALY DRUG – COVID VACCINE CONSENT FORM

Facility Name: _____ Employee _____ Resident _____

Patient Information

Patient Name _____

Date of Birth _____ Age _____ Male/Female _____

Address _____

Phone _____

Insurance Information:

Plan Name: _____ Cardholder Member ID # _____

Group # _____ Bin # _____ PCN# _____

Medicare Part A/B ID # (MBI) _____ (Medicare Red, White, and Blue Card)

I am uninsured (Initial Here) _____

- I do not have insurance. I do not have Medicare, Medicaid or any other private or government-funded health benefits.
- Please bill my vaccine administration fee to the US Health Resources & Service Administration’s COVID-19 Program for Uninsured patients.
- Please provide SS# _____
or
- Driver’s License # & State _____

I authorize Daly Drug to release information and request payment. I certify the information given is correct and accurate in applying for payment under Medicare, Medicaid, or the HRSA COVID-19 Program for Uninsured Patients.

I understand Daly Drug may be required to or may voluntarily disclose health information to my Primary Care Physician, my insurance plan, health systems and hospitals, and State or Federal registries for purposes of treatment, payment or health care operations.

I give consent to Daly Drug to administer the COVID 19 Vaccine.

X _____ Date _____
Signature of patient to receive vaccine (or parent, guardian, or authorized representative)

Name of guardian, authorized representative, or parent.