COVID-19 Vaccine Intake Form

GDD Pharmacy Services, Inc.

Patient Information

Last Name | First Name | Date of Birth

Gender | Race/Ethnicity (used for reporting purposes only)

Home/Cell Phone | Email Address

Address | City | State | Zip

Doctor Information

Primary Care Provider (PCP) Name | PCP Phone Number | PCP Fax Number

PCP Address | City | State | Zip

Insurance Information

Prescription Insurance:

(Private or Medicaid Coverage)

Prescription Benefit Plan Name | Cardholder's ID #

RX Group ID | RX BIN # | RX PCN

Are you the Primary Card Holder? ☐ Yes ☐ No

If **NO**, list Primary Cardholder's DOB

Medicare:

Is the patient over the age of 65 or eligible for Medicare? ☐ Yes ☐ No

If **YES**, please provide the Medicare A/B Identification number:

Refer to your Medicare Red/White/Blue Card

*Note: This is **required** for ALL patients over the age of 65 OR Medicare eligible regardless of medical coverage*

If uninsured, you must check the box below to attest that the following information is true and accurate:

☐ I do not have any insurance, including but not limited to Medicare, Medicaid or any other private or government-funded health benefit plan.

In order to have your vaccine administration fee paid for by the United States Health Resources & Services Administrations COVID-19 Program for Uninsured Patients**, Please provide either (a) a valid Social Security Number, (b) state identification number and state of issuance, OR (c)a driver's license number and the state of issuance.**

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Social Security Number or State Identification Number & State or Driver's License Number & State

•I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient and confirm that the patient is at least 18 years of age; or (c) authorized to consent for vaccination for the patient named above. Further, I hereby give my consent to administer the COVID-19 vaccine.

• I understand that this product has not been approved or licensed by FDA, but has been authorized for emergency use by FDA, under an EUA to prevent Coronavirus Disease 2019 (COVID-19) for use in individuals 18 years of age and older; and the emergency use of this product is only authorized for the duration of the declaration that circumstances exist justifying the authorization of emergency use of the medical product under Section 564(b)(1) of the FD&C Act unless the declaration is terminated or authorization revoked sooner.

. • I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine and have received, read and/or had explained to me the Emergency Use Authorization Fact Sheet on the COVID-19 vaccine I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.

• I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes (or more in specific cases) after administration for observation. If I experience a severe reaction, I will call 9-1-1 or go to the nearest hospital.

• I acknowledge that GDD Pharmacy Services, Inc. will include my personal immunization information in the Pennsylvania Immunization Registry (PA SIIS) and my personal immunization information will be shared with the Centers for Disease Control (CDC) or other federal agencies.

• I further authorize GDD Pharmacy Services, Inc. to submit a claim to my insurance provider or Medicare Part B without supplemental coverage payment for me for the above requested items and services. I assign and request payment of authorized benefits be made on my behalf to GDD Pharmacy Services, Inc. with respect to the above requested items and services>

Signature of Patient/Authorized Representative_____Date_____