Covid Vaccine Insurance Info

Name: ________________________________ DOB: _____________

Non Medicare Patients:

Plan Name (ex: Aetna, Keystone etc..) ___________________________________

Rx ID: ___________________________________

Rx PCN: _________________________________

Rx Group:________________________________

Are you the(circle) : Cardholder Spouse Dependent Student

Medicare Eligible Patients:

Plan Name (ex: Aetna, Keystone 65 etc..) ___________________________________

Rx ID: ___________________________________

Rx PCN: _________________________________

Rx Group:________________________________

Medicare ID(red, white and blue card):________________________________

Signature ____

By signing this form you are allowing Medical Tower Pharmacy to bill the administration cost to your plan.