MEDICINE SHOPPE-COVID VACCINE CONSENT FORM

Patient Information

Patient Name_____

Date of Birth_____ Age _____ Male/Female_____

Address_____

Phone_____

Insurance Information

Plan Name: _____ Cardholders 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 Medicine Shoppe Pharmacy to release information and request payment. I certify the information given is correct and accurate in applying under Medicare, Medicaid, or the HRSA COVID-19 Program for Uninsured Patients.

I understand Medicine Shoppe Pharmacy may be required to or may voluntarily disclose Health Information to my Primary Care Physicians, 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 Medicine Shoppe Pharmacy 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