

**Cleveland County Health Department
Consent for Seasonal Flu/Pneumonia Vaccine**

Please Print

What type of medical insurance do you have? (Check all that apply & give card to clerk to copy)

- Medicare Medicaid Private Insurance None (Self-Pay)

Circle Yes(Y) or No(N) **Hispanic- Y N** **Primary Language** _____

Are you pregnant? **Y N** Have you ever had a reaction to a Flu/Pneumonia shot? **Y N**

Have you had an anaphylactic reaction to eggs? **Y N** Do you have a Family Planning Waiver ? **Y N**

Are you allergic to latex? **Y N**

Last Pneumonia vaccine?

Last Name		First Name		Middle Initial	Birthdate	Age
Race	Sex	Social Security Number			Marital Status	
Address (Street number and name)					City	
State	Zip Code	County	Phone Number			

Complete if vaccine recipient is age 6 months through 18 years old:

<p>My Child is: (Please check <input checked="" type="checkbox"/> all that apply)</p> <p><input type="checkbox"/> American Indian or Alaskan Native</p> <p><input type="checkbox"/> Has Medicaid Recipient I.D. number _____ - _____ - _____</p> <p><input type="checkbox"/> Has no Medical Insurance</p> <p><input type="checkbox"/> Has medical insurance but it does not cover immunizations</p>

Cleveland County Health Department Notice of Privacy Practices Given

I have read or have had explained to me the information in the appropriate *Influenza and/or Pneumonia Vaccine Information Statement(s)*. I have had a chance to ask questions and they were answered to my satisfaction. I believe I understand the benefits and risks of receiving the Flu and/or Pneumonia vaccine(s) and ask that the vaccine(s) be given to me or to the above named person for whom I am authorized to make this request. To the best of my knowledge, I am not allergic to any component of the Flu and/or Pneumonia vaccine(s) and do not have any other medical condition that would prevent me from receiving the vaccine(s).

× _____ **Date:** _____

Signature of person authorized to give consent

HD=High Dose SQ-State Quadrivalent PQ- Private Quadrivalent ID- Intradermal

Date Administered: _____	Prov.# _____	L deltoid	R deltoid	(R) ID	(L) ID
Lot#/Vaccine Manufacturer _____		HD ID SQ PQ	L thigh	R thigh	Nasal
Signature of Vaccine Administrator _____			VIS Date: 8/19/2014		

Pneumonia

Date Administered: _____	Prov.# _____	L deltoid	R deltoid
Lot #/Vaccine Manufacturer _____			
Signature of Vaccine Administrator _____			VIS Date-10/06/09

**CLEVELAND COUNTY HEALTH DEPT
FLU/PNEU ENCOUNTER FORM**

CHECK Y/N	
VFC Eligible	
SEE BELOW	
Medicaid	
Private Ins	
Medicare	
Self Pay	

Date	Time

Past Due Balance	\$			
------------------	----	--	--	--

MUST MEET CRITERIA FOR STATE VACCINE			
State Supplied	CPT	DIAG	PROV
Flu (PF) (Quad) <36M	90685	V0481	
Flu (PF) (Quad) 3+	90686	V0481	
Flu (Quad) <36M	90687	V0481	
Flu (Quad) 3+	90688	V0481	
Flu Mist (Quad) 2 - 18	90672	V0481	
Pneu (CH) (STATE)	90732	V0382	

IM ADMIN FOR CHILDREN	
1st Injection	90471IM
2 or more	90472IM

For 90472--specify # of vaccine in QTY and link to DIAG

Intranasal/Oral Only	
Use	90473IM
Flumist Only	

Intranasal/Oral w/Injectables	
Use	90474IM
Flumist w/other inject	

**EP MODIFIER
REQUIRED <21 FOR
MEDICAID OR TJ
MODIFIER REQUIRED
FOR RNHC.**

IM ADMIN FOR ADULTS	
1st Injection	90471
2 or more	90472

Purchased Vaccine	CPT	DIAG	PROV
Self Pay (> 18) or Insurance Clients			
Flu (PF) (Quad) <36M	90685	V0481	
Flu (PF) (Quad) 3+	90686	V0481	
Flu (Quad) <36M	90687	V0481	
Flu (Quad) 3+	90688	V0481	
Pneu (AH & CH)	90732	V0382	

MEDICARE/MEDICARE REPLACEMENT POLICY	CPT	DIAG	PROV
Flu (PF) (Quad) 3+	90686	V0481	
Flu (Quad) 3+	90688	V0481	
Flu HD 65 +	90662	V0481	
Pneumonia	90732	V0382	

**If giving Flu and Pneumonia together use diagnosis code V066 only.
Use G0008 for Flu Administration and G0009 for Pneumonia Administration.**

*** STATE SUPPLIED VACCINE MUST BE
EDITED TO ZERO CHARGE.**

IF CHILD RECEIVES PNEMONIA AND FLUMIST AT SAME TIME PLEASE USE 90471IM FOR PNEMONIA AND 90474IM FOR FLUMIST.

VFC GUIDELINES (STATE) <19 (Check all that apply)	
Medicaid	
American Indian	
Alaskan Native	
Uninsured	
Underinsured	

FOR ALL OTHER IMMUNIZATIONS PLEASE ATTACH AH, CH, AND/OR FP ENCOUNTER!

For Medicare Patients receiving Flu or Pneu: On the ESB screen all clerks will need to change the Billing Provider NPI # located right above Chief Complaint to 1639244452.