Front Range FLU SHOTS LLC
ON-SITE IMMUNIZATIONS

CONSENT FOR TREATMENT INFLUENZA Immunization

✓ Please make checks payable to Front Range Flu Shots, LLC *or* FRFS

Please print. Use name and gender as it appears on insurance card of person getting vaccinated.

Last Name	First Name	Middle Initial	Birthdate (MM - DD - YYYY)	Age	❑ Male ❑Female Gender
			/ /		

Home Address Street Apt. # City State Zip Code | Phone# ❑ Home or ❑ Cell

Insurance Billing. Answer questions and provide all insurance Member ID#'s You are responsible for payment if vaccination is not covered by insurance. Benefits are subject to all contract limitations and the member's eligibility status. INSURANCES NOT ACCEPTED include but are not limited to: Anthem BCBS, Kaiser, Medicaid, Cigna True Choice Medicare, Devoted Health Medicare Advantage, Humana HMOX, UHC Centura, Freedom, DU Plans.

❑ Medicare Advantage Plan Name _____ ❑HMO ❑PPO Member ID _____

Provider Services / Customer Service Phone Number listed on back of card _____

❑ Medicare Part B # _____ ❑ Railroad Medicare # _____

❑ Yes ❑ No Permission to email for insurance or medical purposes? Email address: _____

❑ Yes ❑ No Permission to leave a voice or text message? If yes, specify: ❑ Home ❑ Cell ❑ Voice Message ❑ Text Message

❑ Aetna ☐ First Health ☐ Meritain ❑ Cigna ❑ HealthPartners ❑ Humana ❑ UMR* ❑ UnitedHealthcare (UHC)*

Insurance Member ID #	Group #	*Issuer/Payer ID# UMR & UHC only.	*Insurance Plan Name UHC policies only.	Phone # Provider Services listed on back of card

❑ Self ❑ Spouse ❑ Child ❑ Other ☐ Male ☐ Female

Patient Relationship to Policy Holder If you are a Spouse, Child, or Other provide:	Policy Holder Name For Spouse, Child, or Other	Policy Holder Member ID For Spouse, Child, or Other	Policy Holder Birthdate (MM/DD/YYYY) Gender For Spouse, Child, or Other

Answer the following questions, sign, and date below:

1. Have you ever had a flu immunization before? Yes No
2. Do you currently have a fever, chills, or moderate or severe acute illness with or without fever? Yes No
3. Do you have a cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, or diarrhea? Yes No
4. Have you ever had an adverse or allergic reaction to any component of the vaccine, including thimerosal? Yes No
5. Do you have a history of Guillain-Barre Syndrome (a severe paralytic disease, also called GBS)? Yes No
6. Have you ever had a bad reaction to any other vaccine? Yes No
   Explain any adverse or allergic reactions: _____

★ The current applicable CDC *Influenza Vaccine Information Statement* has been provided to me. I have read or have had explained to me the information. I have had a chance to ask questions and, if any, they were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and I ask that the vaccine be given to me or to the person named on this form for whom I am authorized to make this request. I agree that Front Range Flu Shots, LLC (FRFS) shall have no responsibility or liability if I or the named person contract influenza or any other respiratory diseases or suffer any adverse reaction following administration of the influenza vaccine.

★ **Notice of Privacy Practices:** The information on the consent form is the only information FRFS has about you. Information may be used and disclosed for insurance reimbursement purposes and to provide emergency treatment if an emergency develops as a result of this immunization. Upon request, a receipt or copy of this form can be sent to you or an authorized person via mail, email, or fax. Any other release would require your authorization. You can review and request a copy of *Notice of FRFS's Privacy Practices.*

★ **CIIS Notification Information:** You/your child's vaccine information may be reported to the Colorado Immunization Information System (CIIS), a confidential, secure, statewide immunization registry. You may choose to exclude you/your child's information from CIIS at any time. Contact FRFS for further information.

★ I understand that I am responsible for payment to FRFS if vaccination is not fully covered by insurance company and there is a $30 fee for returned checks**.**

Signature of Responsible Person: _____ Date: _____

Insurance Coding and Billing Information for Influenza Vaccination

Front Range Flu Shots, LLC • 7421 S. Curtice Ct., Littleton, CO 80120
Phone 303-797-3396 • Fax 303-797-3397 • Federal Tax ID 743077363 • NPI 1598801615

Influenza Type	Trivalent Shot	Trivalent Flucelvax Shot	Fluzone High Dose Shot	Seqirus Fluad Shot	Amount Paid
Service Location:	60	60	60	60	
Diagnosis Code: ICD-10	Z23	Z23	Z23	Z23	
Vaccine Admin. Code:	90471	90471	G0008	G0008	
Vaccine Code:	❑ 90656 (S) ❑ 90658 (M)	❑ 90661	90662	90653	$_____

Injection site 0.5mL
☐ L Deltoid
☐ R Deltoid

VIS Provided: Inactivated Influenza Vaccine 1/31/2025

RN _____ Date _____
Mfg
Lot #
Exp. Date

Clinic Location: _____ 8.7.25 Invoice_____

❑Credit Card #_____ Charged at Clinic ☐ Yes ☐ No Email: Name No# Exp. Date Security Code Zip ❑Comp ❑Cash ❑Check #_____