

HEALTH DEPARTMENT

Flu Clinic Encounter Form

Primary Insurance:

☐ SelectHealth ☐ United Health Care ☐ Cigna ☐ EMI Health ☐ Aetna
☐ None / not listed ☐ Medicare ☐ Medicaid ☐ PEHP ☐ Blue Cross Blue Shield

(We are NOT contracted with: Cigna Connect; UHC Student Resource / DMBA; BCBS FocalPoint / CDHP / SaveWell / Student Resource / Ind&Fam; EMI Health Ez / Network Care;)

First Name _____ Middle Name/Initial _____ Last Name _____ Date of Birth _____
MONTH DAY YEAR

Age _____ Sex _____ Race _____ Y N ; Y N
 Hispanic? _____ Phone; may we text this #? _____ Email Address _____

Mailing Address _____ City _____ State _____ ZIP Code _____

Relationship to person receiving treatment: ☐ Self ☐ Parent/Guardian ☐ Other: _____

If not self: Parent's Name _____ Parent's Date of Birth _____ Name of Insured Person _____ Insured's Date of Birth _____

- Are you feeling well today? **Y** or **N**
- Allergies to foods or medications? **Y** or **N** If yes, type of allergy: _____
- Any problems with previous vaccines / fainting? **Y** or **N**
- Have you received any vaccines in the past 30 days? **Y** or **N**
- Have you had blood products in the past 6-11 months? **Y** or **N**
- Any problems with your immune system? **Y** or **N**
- If you are female and at least 9 years old, could you be pregnant? **Y** or **N** or **N/A**

Initial: _____ I consent to receive treatment and have had the opportunity to review SLCoHD's Conditions of Treatment. I agree I am responsible for any charges not covered by my health insurance.
 _____ I have had the opportunity to review SLCoHD's Notice of Privacy Practices.

By signing, you indicate that you have read, understand, and agree to these terms and that you are the patient, guarantor, the patient's legal representative, or legally authorized to sign this agreement and accept these terms.

Signature _____ Print Name _____ Date _____

STOP! HEALTH DEPARTMENT USE ONLY BELOW

ADMIN CODES	Private Purchase (PP)	VFC	Grant/Special Project (SP)	Payor Code	Medicare Part B
	90471 - First Vaccine	90471 (SL) - First Vaccine	90465 - First Vaccine	90455 - First Vaccine	G0008 - Flu
	90472 - Add'l +Units _____	90472 (SL) - Add'l +Units _____	90466 - Add'l +Units _____	90456 - Add'l +Units _____	G0009 - Pneumo
	90473 - FluMist / Oral/Nasal	90473 (SL) - FluMist / Oral/Nasal	90467 - FluMist / Oral/Nasal	90457 - FluMist / Oral/Nasal	90480 - COVID-19
	90480 - COVID-19	90480 (SL) - COVID-19	90480 - COVID-19	90480 - COVID-19	Part D = PP Coding

OUTBREAK CODES					*Preferred brands not guaranteed	
☐ Measles	☐ Measles GAMMA	☐ Pertussis	☐ MCV4	☐ Flu Outbreak	FLU Service Lot # _____ Site _____	
☐ Mumps	☐ Hepatitis A	☐ Hepatitis B	☐ Men B	☐ Flu (Grant)		
☐ Rubella	☐ Hepatitis A GAMMA	☐ Varicella	☐ Mpox			

COVID-19 Service (Nuvaxovid*)			COVID-19 Service (Spikevax/mNEXSPIKE*)			CPT	Dose	Service (ICD10 - Z23)
Lot #	Site		Lot #	Site		90662	0.5cc	High Dose Fluzone ≥ 65 yrs
						90660	0.2cc	FluMist (Intranasal) 2-49 yrs
CPT	Dose	Service (ICD10 - Z23)	CPT	Dose	Service (ICD10 - Z23)	90673	0.5cc	Flublok ≥ 9 yrs
91304	0.5cc	Nuvaxovid (Novavax) 12+	91322	0.5cc	Spikevax (Moderna) 12+	90656	0.5cc	Pres. Free Tri Flu ≥ 6 mos
		Discussed vaccination risks and benefits under shared clinical decision	91321	0.25cc	Spikevax (Moderna) 6m-11y	90661	0.5cc	Flucelvax Tri Flu ≥ 6 mos
			91323	0.2cc	mNexspike 65+ (12-64 w/risk factors)			

CPT	ICD10	Service	Lot #	Site	CPT	ICD10	Service	Lot #	Site
90707	Z23	MMR ≥ 1 yr							

Provider Name PRINTED, LEGIBLY		Date:	OFFICE USE ONLY *if applicable	
Provider Signature: _____			Payor Code:	_____
			Payor Name:	_____

OFFICE USE ONLY				
Client PID Number:	Registered - Employee Name:	Close Out - Employee Signature:	Date:	Transact Rx ONLY Last 4 # SSN

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Seguro Primario:

☐ SelectHealth ☐ United Health Care ☐ Cigna ☐ EMI Health ☐ Aetna
☐ None / not listed ☐ Medicare ☐ Medicaid ☐ PEHP ☐ Blue Cross Blue Shield

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Primer Nombre		Segundo Nombre		Apellido		Fecha de Nacimiento MES DÍA AÑO	
Años	Sexo	Raza	S N Hispano/a o Latino/a	Teléfono	¿podemos texto a este número?	Correo electrónico	
Dirección de envío				Ciudad		Estado	
Relación con la persona que recibe el tratamiento:				☐ Mismo ☐ Padre/Tutor ☐ Otro:			

No yo: Nombre de Padres	Fecha de nacimiento de Padres	Nombre del titular de la póliza de seguro	Fecha de nacimiento del titular de la póliza
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1. ¿Te sientes bien hoy? **Sí o No**
2. ¿Alergias a alimentos o medicamentos? **Sí o No** Especifique: _____
3. ¿Algún problema con vacunas anteriores o desmayos? **Sí o No**
4. ¿Ha recibido alguna vacuna en los últimos 30 días? **Sí o No**
5. ¿Ha tomado hemoderivados en los últimos 6 a 11 meses? **Sí o No**
6. ¿Algún problema con su sistema inmunológico? **Sí o No**
7. Si es mujer y tiene más de 9 años, ¿podría estar embarazada? **Sí o No o N/A**

Iniciales: _____ Doy mi consentimiento para recibir tratamiento y he tenido la oportunidad de revisar las Condiciones de Tratamiento del SLCoHD. Acepto que soy responsable de cualquier cargo no cubierto por mi seguro de salud.
 _____ He tenido la oportunidad de revisar el Aviso de Prácticas de Privacidad del SLCoHD.

Al firmar, usted indica que ha leído, entendido y aceptado estos términos, y que es el paciente, el responsable de pago, el representante legal del paciente o que está legalmente autorizado para firmar este acuerdo y aceptar estos términos.

Firma	Nombre impreso	Fecha
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¡DETENER! SOLO PARA USO DE OFICINA

ADMIN CODES	Private Purchase (PP)		VFC		Grant/Special Project (SP)		Payor Code		Medicare Part B		
	90471 - First Vaccine		90471 (SL) - First Vaccine		90465 - First Vaccine		90455 - First Vaccine		G0008 - Flu		
	90472 - Add'l +Units _____		90472 (SL) - Add'l +Units _____		90466 - Add'l +Units _____		90456 - Add'l +Units _____		G0009 - Pneumo		
	90473 - FluMist / Oral/Nasal		90473 (SL) - FluMist / Oral/Nasal		90467 - FluMist / Oral/Nasal		90457 - FluMist / Oral/Nasal		90480 - COVID-19		
90480 - COVID-19		90480 (SL) - COVID-19		90480 - COVID-19		90480 - COVID-19		Part D = PP Coding			
OUTBREAK CODES								*Preferred brands not guaranteed			
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☐ Mumps		☐ Hepatitis A		☐ Hepatitis B		☐ Men B		☐ Flu (Grant)			
☐ Rubella		☐ Hepatitis A GAMMA		☐ Varicella		☐ Mpox					
COVID-19 Service (Nuvaxovid*)				COVID-19 Service (Spikevax/mNEXSPIKE*)				CPT Dose Service (ICD10 - Z23)			
Lot #		Site		Lot #		Site		90662 0.5cc High Dose Fluzone ≥ 65 yrs 90660 0.2cc FluMist (Intranasal) 2-49 yrs 90673 0.5cc Flublok ≥ 9 yrs 90656 0.5cc Pres. Free Tri Flu ≥ 6 mos 90661 0.5cc Flucelvax Tri Flu ≥ 6 mos			
CPT	Dose	Service (ICD10 - Z23)		CPT	Dose	Service (ICD10 - Z23)					
91304	0.5cc	Nuvaxovid 12+ (2025-2026)		91322	0.5cc	Spikevax 12+ (2025-2026)					
Discussed vaccination risks and benefits under shared clinical decision making				91321	0.25cc	Spikevax 6m-11y (2025-2026)					
				91323	0.2cc	mNEXSPIKE 12+ (2025-2026)					
CPT	ICD10	Service		Lot #	Site	CPT	ICD10	Service		Lot #	Site
90707	Z23	MMR ≥ 1 yr									
Provider Name: _____ Date: _____ Provider Signature: _____								OFFICE USE ONLY *if applicable Payor Code: _____ Payor Name: _____			
OFFICE USE ONLY											
Client PID Number:		Registered - Employee Name:			Close Out - Employee Signature:			Date:		Transact Rx ONLY Last 4 # SSN	