|  |
| --- |
|  **Patient Supplemental Information**IHS will administer the COVID-19 vaccine at no cost for the dose to IHS employees, beneficiaries, and others in accordance with IHS authority. IHS may administer the vaccine to non-beneficiaries in accordance with IHS authority, which permits but does not require IHS to treat non-beneficiaries to prevent the spread of communicable disease, subject to administration charges. IHS may seek reimbursement for COVID-19 vaccine administration fees for any recipient to the extent such fees are covered by a health care program or plan. |
| **PATIENT or PATIENT REPRESENTATIVE to Complete Sections I-III – please PRINT** |
| **Section I: Patient Information** |
| **Patient First Name:**  | **Patient Last Name:**  | **Date of Birth:** | **For staff use only** |
| **Identity verified with:** |
| * CDIB
 |
| * State/Federal ID
 |
| **Staff initials:** |
| **Social Security Number:**  | **Primary Language:**  | **Birth Sex:**  | **Marital Status:**  |
| * English
 | * Female
 | * Single
 | * Separated
 |
| * Other:
 | * Male
 | * Married
 | * Widow/Widower
 |
| * Decline to answer
 | * Other:
 |
| **Ethnicity:**  | **Race:** | **Tribal Membership:**  |
| * Not Hispanic or Latino
 | * White
 | * Native American or Alaska Native
 |
| * Hispanic or Latino
 | * Asian
 | * Black or African American
 |
| * Decline to answer
 | * Decline to answer
 | * Native Hawaiian or Pacific Islander
 |
| * Other:
 | * Other:
 |
| **Address:** | **State:** | **Zip Code:**  | **Phone Number:**  |
| **Emergency Contact First Name:** | **Emergency Contact Last Name:** | **Emergency Contact Phone Number:** |
| **Section II: Third Party Resources** |
| **Are you covered by any of the following third party resources? If yes, please select which one:** |
| * Medicare
 | * Medicaid
 | * Private Insurance/ACA Plan
 |
| * VA
 | * I do not have any third party resources
 | * Other:
 |
| **Policy Plan Name:** | **Policy Number:** | **Member Number:** |
| * Check here if Policyholder is the same as Patient and skip to Section III
 |
| **Policy Holder First Name:**  | **Policy Holder Last Name:**  | **Policyholder DOB:** (XX/XX/XXXX) |
| **Policyholder Address**:  | **Relationship to Policyholder:** |
| Continue on back to complete information |
| **PATIENT or PATIENT REPRESENTATIVE to Complete Sections I-III – please PRINT** |
| **Section III: Assignment of Benefits and Acknowledgement of Receipt of IHS Notice of Privacy Practices to be completed by Patient or Patient Representative** |
| * **VERIFICATION STATEMENT:** I verify I have answered the information to the best of my knowledge and ability
* **ASSIGNMENT OF BENEFITS:** I authorize the release of information concerning any health care provided to me by the **IHS Facility** to my health insurance company and/or other appropriate health insurance agencies. I further authorize the payment of benefits to the **IHS Facility** on my behalf, this authorization covers previous visits and will be in effect for one year from the date of signature, unless I revoke it. I agree to forward to **IHS Facility** all health insurance and other third‐party payments I receive for services rendered to me immediately upon receipt. I understand that the health care provider may release information to the **State Immunization Information System (SIIS)** and is required to release information to the Centers for Disease Control and Prevention (CDC) that I (or for the person for whom I am authorized to consent) have received this COVID‐19 vaccine.
* **ACKNOWLEDGEMENT:** I hereby acknowledge receipt of the Indian Health Service (IHS) Notice of Privacy Practices
 |
| **Patient or Patient Representative Signature:**  | **Date:** |
| **Section IV: IHS Staff Use Only**  |
| **Patient Name:** | **Chart Number:** | **Patient Date of Birth:**  |
| **IHS Staff Signature:**  | **Date:** |