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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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:** | | | | |