



WelCore Health, LLC. 718 Oak Street, Grand Forks, ND 58201-4460
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bobbywelcorehealth@gmail.com www.welcorehealth.com (August 2018)

Print Name (required): Last Name: _____ First Name: _____ Middle Initial: _____			Date of Birth: _____	Age: _____	Circle one: Male Female	Native American or Alaska Native? (circle) Yes No
Mailing Address: _____		City: _____	State: _____ 9 Digit Zip Code: _____	Can we text or e-mail you with questions? Yes No E-mail or Phone Number (include area code): _____		

We accept insurance from:

Aetna
Blue Cross Blue Shield (any state)
CCStpa
Cigna
EPNI
Health Partners
Health Choice Network
Health Cost Solutions
Health Net (Tricare)
Humana
 Choice Care Network
Medica
Medicaid
Medicare
Medicare Advantage Plans
 Medica
 Humana
 Sanford
Preferred One
Railroad Medicare
Sanford Health
United Health Group
Vaccines for Children (VFC)
 We provide free vaccine and low cost vaccine administration for eligible children including uninsured, underinsured, Native American and Alaska Native.

TO DETERMINE PAYMENT: Please check appropriate box below.

Medicaid Number _____ MEDICARE PART B _____

No Insurance. *For uninsured **children** we request a \$20.99 donation to cover vaccine administration. *No child will be turned away regardless of the ability to pay for vaccine administration. (cash or check, payable to **WelCore Health**)

Insured – my insurance pays for flu vaccine. If your insurance company is not listed, we require payment at the time of the vaccine. You will be given a receipt to file with your insurance company.

POLICY HOLDER INFORMATION:
 Policy Holder Name (Last, First, MI) _____ Date of Birth: _____

Circle one: Male Female Policy Holder Relationship to person being vaccinated: _____

Insurance Company Name: _____
 Policy Number: _____
 Health Net (formerly Tricare: Social Security Number or DoD#): _____

Please circle a response.

Yes	No	Has the person to be vaccinated had a serious reaction to a vaccine in the past? Describe Symptoms on back.
Yes	No	Has the person to be vaccinated has Guillain-Barre Syndrome within 6 weeks of getting a vaccine?
Yes	No	Flu vaccine for children 6 months – 8 years: Has your child received a total of at least 2 doses of flu vaccine in the past? If no or unknown give 2 doses four weeks apart. If yes, give 1 dose.

ACKNOWLEDGEMENT, AUTHORIZATION & ASSIGNMENT OF BENEFITS: A copy of the Vaccine Information Statement has been provided. I have read the information. I had an opportunity to ask questions and believe I understand the benefits and risks of the vaccine. **I consent to the administration of the vaccine to be given to the person named above and I am authorized to give this consent.** Information collected on this form will be used to document authorization of receipt of vaccine and I consent to the exchange of this information with the ND Immunization Information System and with other entities in accordance with ND Century Code 23-01-05.3. As an individual I am legally obligated to pay for medical services provided to the client or a guarantor of payment, **I agree to pay and am financially responsible** for the established charges provided to the client not covered by third-party payers. I assign and **authorize any third party payer/insurer** to make direct payment to WelCore Health. I authorize the release of any medical or other information necessary to process this claim. I acknowledge that I have been provided with WelCore's Notice of Privacy Practices. It is available on line at www.welcorehealth.com.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN _____ DATE _____

OFFICE USE ONLY:							
Vaccine	Route	Vis Date	Mfg.	Lot Number	State or Private	Admin. Site	Nurse's Initials
Influenza Inactive	IM	08/07/2015	AZ Seq SP GSK		S P	RD LD RT LT	
Flumist	Intranasal	08/07/2015	AZ Seq SP GSK		S P	RD LD	
Tdap	IM	02/24/2015	AZ Seq SP GSK		S P	RD LD	

Assessment/ Teaching Nurse: _____ Does the person to be vaccinated feel ill today? Yes No

Comments: _____