**Recipient Registration and COVID-19 Vaccine Administration Form**

**Recipient Full Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date of Birth** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

**Recipient Email Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No email

**Have you already registered in the COVID-19 Vaccine Portal?**  Yes  No

**Home Phone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Mobile Phone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Zip Code:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **County:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**State:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Best way to contact you:**  SMS/Text Message  Email  Both  None

**Recipient Race:**  American Indian/Alaska Native  Asian  Black/African American

Native Hawaiian or Other Pacific Islander  White  Other  Unknown

**Recipient Ethnicity:**  Hispanic or Latino  Not Hispanic or Latino  Unknown

**Recipient Gender**:  Male  Female  Other  I do not want to specify

**Preferred Language:**  English  Vietnamese  Arabic  French

Spanish  Hindi  Other  Decline to state

**Disabilities:**  Not Disabled  Cancer  Cognitive (Psychological or Psychiatric)

Neurological  Physical (Mobility)  Respiratory

Sensory (Vision or Hearing)  Other (Please Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

☐ **I hereby** **give my consent** to the licensed healthcare provider administering the vaccine, as applicable (each an ‘applicable Provider’), to share my personal, demographic and health condition information in order to provide me with vaccination services for the COVID-19 vaccine.

**Recipient Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OFFICE USE ONLY**

**Verbal Consent for COVID-19 Vaccine Obtained**

**Site of Injection:**  Right Deltoid, IM  Left Deltoid, IM Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dose:**  First Dose  Second Dose  Additional Dose **Manufacturer sticker (optional)**

**Route:**  Intramuscular  Subcutaneous  Intradermal

**Administration Date:** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

**Administration Time:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Vaccine Product:**  Moderna  Pfizer  Janssen

**Lot #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Exp:** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_

**Vaccine administered by (Clinician Name):**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Vaccinating Clinic Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Form Version 12 – 9/10/2021 – North Carolina COVID-19 Vaccine Management System*

**THE VACCINES ARE FREE TO EVERYONE, REGARDLESS OF WHETHER YOU HAVE PRIVATE OR GOVERNMENT INSURANCE OR NO INSURANCE AT ALL.**

**If you have your insurance card with you today or if you are not insured, you do not need to fill out the insurance information.**

INSURANCE INFORMATION/AUTHORIZATION TO BILL (copy of front and back of insurance card preferred for verification)  
Insurance Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Claims Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Subscriber Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_

*S*ubscriber Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize payment from 3rd Party Payer (Insurance) and Medicare/Medicaid be made on my behalf to the licensed healthcare provider administering the vaccine for services provided. I understand that my signature above will serve as legal “signature on file” for purposes of filing insurance/Medicaid claims and payment of benefits to the licensed healthcare provider administering the vaccine for services rendered.

**PREVACCINATION CHECKLIST FOR COVID-19 VACCINES**

**PLACEHOLDER**

**OFFICE USE ONLY (VACCINE BILLING INFORMATION)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1st Dose  ☐ | **91301-SL** (Moderna SARS-CoV-2 Preservative free vaccine) **0011A** (Administration of 1st dose of Moderna Vaccine)  Dx z23 | 1st Dose  ☐ | **91300-SL** (Pfizer SARS-CoV-2 Preservative free vaccine) **0001A** (Administration of 1st dose of Pfizer Vaccine)  Dx z23 | 1st Dose  ☐ | **91302-SL** (Janssen SARS-CoV-2 Preservative free vaccine) **0031A** (Administration of 1st dose of Janssen Vaccine)  Dx z23 |
| 2nd Dose  ☐ | **91301-SL** (Moderna SARS-CoV-2 Preservative free vaccine) **0012A** (Administration of 2nd dose of Moderna Vaccine)  Dx z23 | 2nd Dose  ☐ | **91300-SL** (Pfizer SARS-CoV-2 Preservative free vaccine) **0002A** (Administration of 2nd dose of Pfizer Vaccine)  Dx z23 |  |  |
| 3rd Dose  ☐ | **91301-SL** (Moderna SARS-CoV-2 Preservative free vaccine) **0013A** (Administration of 3rd dose of Moderna Vaccine) | 3rd Dose  ☐ | **91300-SL** (Pfizer SARS-CoV-2 Preservative free vaccine) **0003A** (Administration of 3rd dose of Pfizer Vaccine) |  |  |