Good Value Pharmacy

COVID-19 VACCINATION Screening and Consent Form

Patient's Name ____ Date ______________________

Address________________________ Zip________ City______________ Phone Number____________________

Date of Birth ______________ Last 4 SSN__________ ****Provide an insurance card. Need full SSN if uninsured****

Race ☐ White ☐ Black/African-American ☐ Asian ☐ Pacific Islander ☐ American Indian/Alaska ☐ Other

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Male ☐ Female ☐ Pfizer ☐ Moderna

Mothers Maiden Name (prevents patient mismatch)______________ ☐ 1st dose ☐ 2nd Dose ☐ Booster(s)

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1. Are you currently under isolation or quarantine due to COVID-19? Yes ☐ No ☐
2. Have you received antibody therapy or convalescent plasma for COVID-19 treatment in the past 90 days? If yes, date: ____________________ Yes ☐ No ☐
3. Have you had a positive diagnosis for covid? If yes, date:________________ Yes ☐ No ☐
4. Are you sick today? (fever, cough, shortness of breath, nausea/vomiting in the last 24 hours) Yes ☐ No ☐
5. Do you have a medical condition that puts you at high risk for severe COVID? Yes ☐ No ☐
6. Do you have occupational or institutional exposure to COVID that puts you at high risk of serious complications of COVID?_____________________________ Yes ☐ No ☐
7. Have you ever had a severe allergic reaction to any vaccine or injectable medication? If yes, list medicine/reaction: __________________________ Yes ☐ No ☐
8. Are you pregnant, breastfeeding, or do you have a weakened immune system? Yes ☐ No ☐
9. Are you diagnosed or treated for a moderate to severe immune compromise that may include cancer treatments, organ transplant, HIV, moderate to severe primary immunodeficiency, high dose steroids (or other immunosuppressive drugs), and chronic medical conditions with immune deficiency? ________________________ Yes ☐ No ☐

Good Value Pharmacy participates in the Wisconsin Immunization Registry (WIR) Program. Participation in WIR is required for administration of the COVID-19 vaccine. I agree to allow my COVID-19 vaccination record to be entered into the WIR. I have been given a copy of the FDA Emergency Use Authorization Fact Sheet for the COVID-19 vaccine. I have read the FDA Emergency Use Authorization Fact Sheet and have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of this vaccine and ask that the vaccine be given to me or the person for whom I am authorized to make this request. I have been made aware of the appropriate time I am expected to be monitored for post-vaccination reactions based on my risk factors. I hereby attest to the best of my knowledge that I am currently eligible to receive the COVID-19 vaccine as determined by the Wisconsin Department of Health Services and Wisconsin State Disaster Medical Advisory Committee (SDMAC).

Signature ______________________________________ Date ______________ Time____________

Relationship to Vaccine Recipient (if applicable) ____

COVID Vaccine Administration Record and WIR Entry

FOR OFFICE USE ONLY

COVID-19 Vaccine Administered Route: IM

Lot #: ________________ Expiration Date: 7/22 8/22 9/22 10/22 11/22 Manufacturer: _________________

Site of Injection: ☐ Right Deltoid ☐ Left Deltoid ☐ Entered into WIR

Signature of Vaccine Administrator: ________________________________ Date: ___________ Time: _________

Vaccine Administrator: AB AW BB CY DF EE GC JB JK KB KF LL MS PB RC SC SS

Paid claim: ☐ Payor:_____________ BIN:_________ ID: _______________ PCN: _________ RxGroup:__________

Make sure to update patient’s vaccination card and offer EUA Fact Sheet and V-safe document.

COVID-19 Vaccine Administered Route: IM

Lot #: __________________ Expiration Date: 7/22 8/22 9/22 10/22 11/22 Manufacturer: ___________________

Site of Injection: ☐ Right Deltoid ☐ Left Deltoid ☐ Entered into WIR

Signature of Vaccine Administrator: ________________________________ Date: ____________ Time: _________

Vaccine Administrator: AB AW BB CY DF EE GC JB JK KB KF LL MS PB RC SC SS

Paid claim: ☐ Payor:_____________ BIN:_________ ID: _______________ PCN: _________ RxGroup:__________

Make sure to update patient’s vaccination card and offer EUA Fact Sheet and V-safe document.

Billing info:
Add Incentive Fee and DUR PH MA 3N 15
Medicare: BIN 004766 PCN USFLU Clarification Code 02 for first dose,06 for 2nd, 07 for 3rd, 10 for booster
Medicaid: BIN 004766 PCN WIDME Clarification Code 02 for first dose, 06 for 2nd, 07 for 3rd, 10 for booster
Commercial Plans: Submit to commercial plan using Incentive Fee/DUR/clarification codes
Uninsured: Administer vaccine free of charge, run as cash for $0.00
VA: BIN 004336 PCN ADV Group RX3841 ID 10 digit Veteran ID or SSN
Unresolved claim rejections: Cash out at zero until we are sure claim is not covered

NDC: Moderna: 80777-0273-10 Pfizer: 59267-1025-04 Pediatric Pfizer: 59267-1055-04