Hennepin Healthcare

2023-2024 Vaccine Mobile Clinic Registration Form

Community Organization_____ **Name/Address of site** _____

PRINT IN INK ONLY. REQUIRED INFO FOR CLIENT RECEIVING VACCINE. An HHS representative will be contacting individual noted below if form is ineligible or not completely filled out. Additional demographic information may also be necessary for complete registration.

INTERPRETER/LANGUAGE NEEDED: _____

Last name

First name

Middle name

Sex (M/F) Date of birth (MM/DD/YYYY) Age

Address

City

State Zip

Phone Home or Cell ☐ ☐

COMPLETE THIS BOX IF THE PATIENT IS UNDER 18 YEARS OF AGE

Please provide parent/guarantor info below.

☐ Same as the Policy Holder
(must fully complete Policy Holder box)

☐ Other: (If other, must complete information below)

Full name _____

Address _____

_____

Date of birth _____

Phone _____

Relationship to patient _____

PAYMENT OPTIONS

☐ **Private Insurance** ☐ **MHCP** (MA/MnCare) ☐ **Medicare** ☐ **Uninsured**

Insurance will cover the cost for the health assessment and/or vaccine(s) or cost will be covered by MnVFC or the UUAV programs. Insurance will be billed only if available. The individual will not be charged. Accurate and complete information below is required for successful billing.

Hennepin Healthcare can bill through any insurance. It is the individual's responsibility to check their coverage.

(#1) Primary insurance company name

Insurance ID#

Group #

(#2) Secondary insurance company name

Insurance ID#

Group #

POLICY HOLDER/SUBSCRIBER

☐ **Self (skip section below)** ☐ **Spouse** ☐ **Parent** ☐ **Other**

Policy holder last name

First name

Sex (M/F) Date of birth (MM/DD/YYYY)

Daytime phone number ☐ **Same phone as patient**

Policy holder address ☐ **Same address as patient**

City State Zip