ATTESTATION OF INSURANCE COVERAGE

Pharmacy Note:

The following form is a required document for a mobile COVID-19 vaccine clinic that cannot processes immunizations utilizing the Clinical Services App.

Date: ____________________

Patient Name (First & Last): ____ Phone Number: ___________________________

Section A: Insurance Coverage

Please provide **all applicable** insurance information below. If you have no active insurance coverage, skip section A and complete section B below.

1. ***Pharmacy Insurance Information:***

   Insurance Carrier: _____________________________ Patient ID:______________________________

   Primary Cardholder (Y/N) ______ Dependent Number_________________

   BIN:_________________ PCN:_________________ Group:_________________________

2. ***Medical Insurance Information:***

   Insurance Carrier: _____________________________ Patient ID:______________________________

   Group: ______________________________ Payer ID:___________________________

3. ***Medicare Insurance Information (RED, WHITE & BLUE CARD):***

   Name (as it appears on the card): ____

   Medicare ID #: ___________________________________

Section B: No Insurance Coverage

Complete the section below ONLY if you do not have active insurance coverage.

The Federal government wants to make sure that all individuals can receive the COVID-19 Vaccine regardless of health insurance status. Walmart is participating in the federal government's COVID-19 Uninsured Program. If you do not have insurance, we are asking you to confirm this fact to ensure we correctly file the claim for your vaccination service. We will need one of the below forms of identification.

Driver's License Number: __________________________ **State Issued ID:** ______________________________

- I hereby declare that I do not have insurance coverage of any kind including, but not limited to Commercial Insurance, Medicare, or Medicaid.
- I understand that my lack of insurance does not prevent me from receiving the COVID-19 Vaccine.
- I understand that I will not be charged for the vaccine administration.
- I agree to inform my pharmacists if I am enrolled in Medicaid within the next 30 days.

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Patient Signature