ANNUAL EMPLOYEE
FLU SHOTS 2016
The DeKalb County Health Department, NIU Health Services, and NIU Employee Assistance Program (753-9191) will provide flu shots at the
NIU Holmes Student Center

Wednesday, September 21 10:00 am to 4:00 pm Capital Room
Tuesday, October 25 10:00 am to 4:00 pm Regency Room

We will be offering a “Pre-Completed Form” option. Pre-completing the form removes one step in the process. You are able to complete the flu vaccine administration form prior to the day of the clinic. Go to the Employee Assistance website http://www.hr.niu.edu/serviceareas/employeeassistance/HealthEvents/FluShots.cfm to complete the form and to learn more about the vaccine or choose to complete the form on the other side of this flyer to bring with you.

Pre-Completed Process: (Prefill form and bring with you)
1. Stop at NIU Verification Table
2. Stop and Sign Health Department Roster

Non Pre-Completed Process:
1. Stop at NIU Verification Table
2. Stop and Sign Health Department Roster
3. Pick up form to complete at clinic

Employees who are eligible for Free Flu Shots:
• NIU employees who are the primary insured on any of the State of Illinois employee Health Care Plans including the HMOs or OAPs.

Employees who are not eligible for a free flu shot and must pay $38. This includes:
• Dependents (ages 9 and up) of NIU Employees on one of the State Health Insurance Plans. For dependents under 9 years of age, call Health Department at 815-748-2467 for an appointment.
• Anyone who is not on one of the State of Illinois Care Plans including HMOs or OAPs. Includes those who have waived or opted out of the State of Illinois coverage.

Retirees:
• Retired employees and survivors with the State of Illinois Health Coverage who are not yet eligible for Medicare are also eligible for free flu shots.
• Medicare will be billed for individuals with Medicare Part B coverage. You must bring your Medicare card the day of the flu clinic.
• Medicare Advantage (United Healthcare, Humana, Coventry) will be billed. You must bring your Medicare Advantage health insurance card and a photo ID.

Remember to dress so that your upper arm is accessible. Vaccine will not be given to individuals allergic to eggs, or who report a history of previous adverse reactions to the influenza vaccine.

*Students and Graduate Students with assistantships should receive their flu shots at the NIU Health Services for a reduced price of $23. Call 815-753-9585 for more information.

If you are unable to attend the campus clinics, the flu shot may be obtained at the DeKalb County Health Department, 2550 N Annie Glidden Road, DeKalb, IL. Monday through Friday from 8:30am to 11:30am and 1:00pm to 4:00pm. For more information, call 815-748-2467. The above restrictions also apply if you receive your vaccine at the DeKalb County Health Department. State ID and insurance cards will be required. Flu vaccine must be administered prior to December 31, 2015, in order to be paid by the State of Illinois.
1. ARE YOU ALLERGIC TO EGGS? □ YES □ NO
2. HAVE YOU HAD A FEVER OF 100 DEGREES OR ABOVE IN THE LAST 24 HOURS? □ YES □ NO
3. HAVE YOU EVER HAD A SEVERE REACTION TO A FLU SHOT? □ YES □ NO

MEDICARE ADVANTAGE #

| SOCIAL SECURITY #: (LAST 4 DIGITS - FOR STATE OF ILLINOIS EMPLOYEES ONLY): |
| --- | --- |
| ___ ___ ___ ___ | ___ ___ ___ |

CLIENT INFORMATION

<table>
<thead>
<tr>
<th>PLEASE PRINT LEGAL NAME (AS SHOWN ON MEDICARE CARD):</th>
<th>DATE OF BIRTH</th>
<th>AGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>LAST NAME</td>
<td>FIRST NAME</td>
<td>MI</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STREET ADDRESS</th>
<th>SEX</th>
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<tr>
<td>CITY</td>
<td>COUNTY</td>
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<td>M</td>
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I have received a copy of the vaccine information statement dated August 7, 2015. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and the contraindications to receiving it. I ask that the vaccine be given to me or the person named above for whom I am authorized to make this request. I hereby authorize the DeKalb County Health Department to use the information gained during treatment to bill me or any other potential sources of reimbursement, such as government programs in which I am enrolled or qualify for services. I also received or was offered a copy of the notice of privacy practices of the DeKalb County Health Department dated April 14, 2003. I also understand that I will be charged a discounted fee of $38 if I pay by cash, check, or credit/debit card at the time my flu shot is administered.

I hereby authorize registration of my demographic and service information in the Cornerstone, I-CARE, or other Electronic Medical Records computer systems. I also authorize the DeKalb County Health Department to release service related information regarding the above mentioned client to third party payers. I understand that my insurance company benefits will be made payable to the DeKalb County Health Department. The client/parent/legal representative is responsible for any services not covered by insurance plans. Co-Payments may be due at time of service. My signature below also indicates that all information provided above is true and accurate.

SIGNATURE: __________________________ DATE: ___/___/___

FOR CLINIC/OFFICE USE ONLY

CLINIC/OFFICE ADDRESS: DEKALB COUNTY HEALTH DEPARTMENT, 2550 N. ANNIE GLIDDEN ROAD, DEKALB, IL 60115
VACCINE MANUFACTURER/LOT NUMBER/EXP DATE (LABEL):
SITE OF IM INJECTION: L or R Deltoit
SIGNATURE OF VACCINE ADMINISTRATOR: __________________________ DATE __________________

STATE OF ILLINOIS HEALTH CARE COVERAGE:
☑ State of Illinois Employee ☐ State of Illinois Retiree ☐ Retiree who has Cigna Health insurance

MEDICARE or MEDICARE ADVANTAGE:
☑ Medicare Part B (and has no other insurance)
☐ Medicare Advantage (United Healthcare, Coventry, Humana) MUST COMPLETE BACK SIDE

PRIVATE PAY or PRIVATE INSURANCE: MUST COMPLETE BACK SIDE
☒ Employee who OPT OUT of State of Illinois insurance ☐ Debit/Credit Inv # _________ ☐ Cash
☒ Dependent who has State of Illinois insurance ☐ Check # _________ ☐ Initials: ______

Influenza-Fluarix (36 months and up) 223 90686
Influenza-Flucelvax (4 years and up) 223 90674

☑ Entered in I-CARE
CLIENT REGISTRATION FORM FOR FLU FOR STATE OF IL

2550 N ANNIE GLIDDEN ROAD
DEKALB, IL 60115

DATE: _____/_____/_____

***IF CLIENT IS POLICY HOLDER, SKIP 3-6***

1. Insurance Company Name ____________________________________________

2. Is Policy Holder Employed ☐ Full-Time ☐ Part-Time ☐ Self Employed ☐ Retired ☐ Other (explain)________________________

3. Policy Holder (Insured’s) Name _______________________________________

4. Policy Holder (Insured’s) Home Address__________________________, City______________, IL Zip__________

5. Policy Holder (Insured’s) Date of Birth _____/_____/_____

6. Client’s Relationship to Policy Holder ☐ Child ☐ Spouse ☐ Other (explain)________________________________________

 abducted to official use only

DO NOT DUPLICATE FORM

☐ Copy of insurance card front and back (enlarged and legible)
☐ Copy of Medicare Advantage card
☐ Copy of current driver’s license or current photo ID
☐ If TPL, copy of Medicaid card and copy of insurance card front and back

Practitioner:
— Joseph R. Baumgart, MD NPI# 1235124488
— Cathy Carlson, APN NPI# 1225431653
— Alice Gordon, APN NPI# 1902057342
— Patty Lamp, APN NPI# 1891968921
— Kris McClure, APN NPI# 1053384099
— Donna Płonczynski, APN NPI# 1518977552
— Michael Thornton, MD NPI# 1699703405

☐ Date of EOB ______/_____/_____
☐ Amount Paid $_________________
☐ Date Client Notified ______/_____/_____
☐ Refunded/Charged $_________________
☐ Date Refunded/Charged ______/_____/_____
☐ Initials