SALT LAKE COUNTY HEALTH DEPARTMENT

Outreach Influenza Clinic Encounter Form

Primary Insurance: ☐ SelectHealth ☐ United Health Care ☐ Cigna ☐ EMI Health ☐ Aetna
☐ None / not listed ☐ Medicare ☐ Medicaid ☐ PEHP ☐ Blue Cross Blue Shield *(NOT **FocalPoint** or **Ind&Fam** plans)*

First Name | Middle Name/Initial | Last Name | Date of Birth (MONTH / DAY / YEAR)

Age | Sex | Race | Hispanic? Y N | Phone; may we text this #? Y N | Email Address

Mailing Address | City | State | Zip Code

Relationship to person receiving treatment: ☐ Self ☐ Parent/Guardian ☐ Other: _____

If not self: Parent's Name | Parent's Date of Birth | Name of Insured Person | Insured's Date of Birth

1. Are you feeling well today? (Y) or (N)
2. Allergies to foods or medications? (Y) or (N) If yes, type of allergy: _____
3. Any problems with previous vaccines / fainting? (Y) or (N)
4. Have you received any vaccines in the past 30 days? (Y) or (N)
5. Have you had blood products in the past 6-11 months? (Y) or (N)
6. Any problems with your immune system? (Y) or (N)
7. If you are female and at least 9 years old, could you be pregnant? (Y) or (N) or (N/A)

PRINT

Initial: _____ I consent to receive treatment and have had the opportunity to review SLCoHD's Conditions of Treatment. I agree I am responsible for any charges not covered by my health insurance.

_____ I have had the opportunity to review SLCoHD's Notice of Privacy Practices.

By signing, you indicate that you have read, understand, and agree to these terms and that you are the patient, guarantor, the patient's legal representative, or legally authorized to sign this agreement and accept these terms.

Signature | Print Name | Date

STOP! HEALTH DEPARTMENT USE ONLY BELOW

ADMIN CODES

Private Purchase (PP)	VFC	Grant/Special Project (SP)	Payor Code	Medicare Part B
90471 - First Vaccine	90471 (SL) - First Vaccine	90465 - First Vaccine	90455 - First Vaccine	G0008 - Flu
90472 - Add'l +Units _____	90472 (SL) - Add'l +Units _____	90466 - Add'l +Units _____	90456 - Add'l +Units _____	G0009 - Pneumo
90473 - FluMist / Oral/Nasal	90473 (SL) - FluMist / Oral/Nasal	90467 - FluMist / Oral/Nasal	90457 - FluMist / Oral/Nasal	90480 - COVID-19
90480 - COVID-19	90480 (SL) - COVID-19	90480 - COVID-19	90480 - COVID-19	Part D = PP Coding

OUTBREAK CPT CODES (ICD10 - Z23)

X0482 Measles	X0492 Measles GAMMA	X0504 Outreach Vaccination CPT Code for electronic tracking		
X0483 Mumps	X0487 Hepatitis A	X0486 Pertussis	X0488 MCV4	X0500 Flu Outbreak
X0484 Rubella	X0491 Hepatitis A GAMMA	X0490 Hepatitis B	X0489 Men B	X0493 Flu (Grant)
		X0485 Varicella	X0901 Mpox (ICD10 - B04)	

*Preferred brands not guaranteed

FLU Service

Lot #	Site

COVID-19 Service (Pfizer*)

Lot #	Site

CPT	Dose	Service (ICD10 - Z23)
91320	0.3cc	Comirnaty (30mcg) 12+ (2024-25)
91319	0.3cc	Pfizer (20mcg) 5-11 yrs (2024-25)
91318	0.3cc	Pfizer (10mcg) 6m-4y (2024-25)

COVID-19 Service (Moderna/Novavax*)

Lot #	Site

CPT	Dose	Service (ICD10 - Z23)
91322	0.5cc	Moderna 12+ (2024-2025)
91321	0.25cc	Moderna 6m-11y (2024-2025)
91304	0.5cc	Novavax 12+ (2024-25)

CPT	Dose	Service (ICD10 - Z23)
90662	0.7cc	Fluzone High Dose ≥ 65 yrs
90660	0.2cc	FluMist (Intranasal) 2-49 yrs
90673	0.5cc	Flublok ≥ 18 yrs
90656	0.5cc	Pres. Free Tri Flu ≥ 6 mos
90661	0.5cc	Flucelvax Tri Flu ≥ 6 mos

CPT	ICD10	Service	Lot #	Site
OTHER				
OTHER				

CPT	ICD10	Service	Lot #	Site
OTHER				
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Provider Name: (PRINTED LEGIBLY) **Date:**

Provider Signature:

OFFICE USE ONLY **if applicable*
Payor Code: _____
Payor Name: _____

OFFICE USE ONLY

Client PID Number:	Registered - Employee Name:	Close Out - Employee Signature:	Date:	*Transact Rx* ONLY Last 4 # SSN

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Primer Nombre | Segundo Nombre | Apellido | Fecha de Nacimiento (MONTH / DAY / YEAR)

Años | Sexo | Raza | Hispano/a o Latino/a (S / N) | Teléfono | ¿podemos texto a este número? (S / N) | Correo electrónico

Dirección de envio | Ciudad | Estado | Código Postal

Relación con la persona que recibe el tratamiento: ☐ Mismo ☐ Padre/Tutor ☐ Outro: _____

No yo: Nombre de Padres | Fecha de nacimiento de Padres | Nombre del titular de la póliza de seguro | Fecha de nacimiento del titular de la póliza

1. ¿Te sientes bien hoy? **Sí** o **No**
2. ¿Alergias a alimentos o medicamentos? **Sí** o **No** Especifique: _____
3. ¿Algún problema con vacunas anteriores o desmayos? **Sí** o **No**
4. ¿Ha recibido alguna vacuna en los últimos 30 días? **Sí** o **No**
5. ¿Ha tomado hemoderivados en los últimos 6 a 11 meses? **Sí** o **No**
6. ¿Algún problema con su sistema inmunológico? **Sí** o **No**
7. Si es mujer y tiene más de 9 años, ¿podría estar embarazada? **Sí** o **No** o **N/A**
8. ¿Tiene alguna erupción no diagnosticada o lesiones con aspecto de granos o ampollas? **Sí** o **No**

PRINT

Iniciales: _____ Doy mi consentimiento para recibir tratamiento y he tenido la oportunidad de revisar las Condiciones de Tratamiento del SLCoHD. Acepto que soy responsable de cualquier cargo no cubierto por mi seguro de salud.
_____ He tenido la oportunidad de revisar el Aviso de Prácticas de Privacidad del SLCoHD.

Al firmar, usted indica que ha leído, entendido y aceptado estos términos, y que es el paciente, el responsable de pago, el representante legal del paciente o que está legalmente autorizado para firmar este acuerdo y aceptar estos términos.

Firma | Nombre impreso | Fecha

¡DETENER! SOLO PARA USO DE OFICINA

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OFFICE USE ONLY **if applicable*
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OFFICE USE ONLY

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