Covid-19 Vaccine Insurance/Billing Form

Name: ____

Resident DOB: ____ / ____ / ____ Sex: M___ F___ Social Security #: ___________________

LTC Facility Name: _____________________

Skilled Nursing / Personal Care / Assisted Living / Independent Living / Staff: _______________________

Primary Prescription Insurance Plan: ___________________________ Bin#______________ PCN:________

Member ID/ID #:__________________________ Group: _________ Medicare Part-B ID: ___________

Secondary Prescription Insurance Plan: Y/N?________

***Please include copies of insurance card(s)**

Primary Contact/POA/Responsible Party (full name): ____

POA/Responsible Party Address: ____

POA/Responsible Party Social Security #: ______________________________

POA/Home Phone:_________________ POA/Cell Phone: _________________

Email Address: _______________________________________

(If there are multiple responsible parties, please fill out an individual form for each)

This form MUST be signed and dated by the Individual or Responsible Party for proper billing through your insurance from HersheyCare. Please return via fax (717-534-1707) or email at mbarto@ckcrx.com

Place front of insurance card here and copy before returning to HersheyCare	Place back of insurance card here and copy before returning to HersheyCare