Influenza (Flu) Vaccine Roster Form

Provider Name	Date of Service (One date per roster)
National Provider Identifier (NPI)	

Patient Information (Please PRINT all elements clearly except the beneficiary's signature)

Medicare Number		Date of Birth (MM/DD/YYYY))		Sex: ☐ Male ☐ Female	
First Name		Last Name			MI
Address	City		State		Zip
Patient Signature					
Medicare Number		Date of Birth (MM/DD/YYYY))		Sex: ☐ Male ☐ Female	
First Name		Last Name			MI
Address	City		State		Zip
Patient Signature					
Medicare Number		Date of Birth (MM/DD/YYYY))		Sex: ☐ Male ☐ Female	
First Name		Last Name			MI
Address	City		State		Zip
Patient Signature					
Medicare Number		Date of Birth (MM/DD/YYYY))		Sex: ☐ Male ☐ Female	
First Name		Last Name			MI
Address	City		State		Zip
Patient Signature					
Medicare Number		Date of Birth (MM/DD/YYYY))		Sex: ☐ Male ☐ Female	
First Name		Last Name			MI
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Patient Signature					