Walmart Immunization Clinic Sign Up Sheet

Name: _____

DOB: _____

Address: _____

Phone Number:_____

Insurance Card: (Commercial Insurance or Medicare D)

BIN #: _____

PCN #: _____

Member ID#: _____

RX Group #: _____

Cardholder Name: _____

Medicare A/B: (Covers Flu Vaccine for 60+ years old)

ID #: _____

Date Immunization Desired: October 19th or October 27th (please circle)