Insurance Attestation Form

Date: _____

Patient Name (First & Last): _____ Phone Number: _____

Section A: Insurance Coverage Information

Please provide **all applicable** insurance information below. ***FOR COVID-19 IMMUNIZATIONS ONLY: If you have no active insurance coverage, skip section A and complete section B below.***

Note: For active insurance coverage, but unsure of your insurance information, provide the last 4 digits of your Social Security Number. (Last 4 digits of SSN) - _____

1. ***Pharmacy Insurance Information:***
   Insurance Carrier: _____ Patient ID:_____
   Primary Cardholder (Y/N): _____ Dependent Number:_____
   BIN:_____ PCN:_____ Group:_____

2. ***Medical Insurance Information:***
   Insurance Carrier: _____ Patient ID:_____
   Group: _____ Payer ID:_____

3. ***Medicare Insurance Information (RED, WHITE & BLUE CARD):***
   Name (as it appears on the card): _____
   Medicare ID #: _____

Section B: No Insurance Coverage Attestation

Complete the section ONLY if you are receiving a COVID-19 immunization AND do not have active insurance coverage.

The Federal government wants to make sure that all individuals can receive the COVID-19 Vaccine regardless of health insurance status. Walmart is participating in the federal government's COVID-19 Uninsured Program. If you do not have insurance, we are asking you to confirm this fact to ensure we correctly file the claim for your vaccination service. We will need one of the below forms of identification.

Driver's License Number: _____ **State Issued ID:** _____

- I hereby declare that I do not have insurance coverage of any kind including, but not limited to Commercial Insurance, Medicare, or Medicaid.
- I understand that my lack of insurance does not prevent me from receiving the COVID-19 Vaccine.
- I understand that I will not be charged for the vaccine administration.
- I agree to inform my pharmacists if I am enrolled in Medicaid within the next 30 days.

Patient Signature: _____

Section C: Long Term Care Facility (LTCF) Clinic – *Place of Service Confirmation*

Complete the section ONLY if you are receiving an immunization at a LTCF.

Place a check next to the administration setting below in which you are receiving your vaccination to ensure we correctly file the claim for your vaccination service.

☐Communal Setting at the Long Term Care Facility ***(no reason or signature required)***
☐Patient Room ***(reason and signature required below)***

- I confirm that the vaccination service was provided in my patient room as indicated below.

Reason: _____

Patient Signature: _____