

<b>Pneumococcal Vaccine Roster Form (see warning below prior to administering vaccine)</b>				
<b>Provider Name</b>		<b>National Provider Identifier (NPI)</b>		<b>Date of Service MM/DD/YYYY (One date per roster)</b>
<b>Patient Information (please PRINT all elements clearly except for beneficiary's signature)</b>				
<b>Medicare ID</b>		<b>Date of Birth MM/DD/YYYY</b>		<b>Patient Signature or Signature on file</b>
<b>Last Name</b>		<b>First Name</b>		<b>MI</b> <b>Sex: M/F</b>
<b>Address (No., Street)</b>		<b>City</b>		<b>State</b> <b>Zip</b>
<b>Patient Information (please PRINT all elements clearly except for beneficiary's signature)</b>				
<b>Medicare ID</b>		<b>Date of Birth MM/DD/YYYY</b>		<b>Patient Signature or Signature on file</b>
<b>Last Name</b>		<b>First Name</b>		<b>MI</b> <b>Sex: M/F</b>
<b>Address (No., Street)</b>		<b>City</b>		<b>State</b> <b>Zip</b>
<b>Patient Information (please PRINT all elements clearly except for beneficiary's signature)</b>				
<b>Medicare ID</b>		<b>Date of Birth MM/DD/YYYY</b>		<b>Patient Signature or Signature on file</b>
<b>Last Name</b>		<b>First Name</b>		<b>MI</b> <b>Sex: M/F</b>
<b>Address (No., Street)</b>		<b>City</b>		<b>State</b> <b>Zip</b>
<b>Patient Information (please PRINT all elements clearly except for beneficiary's signature)</b>				
<b>Medicare ID</b>		<b>Date of Birth MM/DD/YYYY</b>		<b>Patient Signature or Signature on file</b>
<b>Last Name</b>		<b>First Name</b>		<b>MI</b> <b>Sex: M/F</b>
<b>Address (No., Street)</b>		<b>City</b>		<b>State</b> <b>Zip</b>

WARNING: Prior to administering pneumococcal vaccination, patient must be asked if they have received a prior pneumococcal vaccination in the past five years. Rely on the patients memory to determine prior vaccination status. If patient is uncertain whether they were vaccinated within the past five years, administer the vaccine. If patient is certain they were vaccinated within past five years, do not revaccinate.