

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