

Pneumococcal Vaccine Roster Form (see warning below prior to administering vaccine)					
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	
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

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.