



Pneumococcal Vaccine Rost	er Form (s	ee warning be	low prior to ad	lministering	g vacc	ine)
Provider Name		National Provider Identifier		Date of Service MM/DD/YYYY		
Provider Name		(NPI)		(One date per roster)		
Patient Information (please	PRINT all a	lements clearly	except for bene	ficiary's sig	nature)	
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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.