Mercer County Health Department

305 NW 7th Street
Phone: 309-582-3759
Fax: 309-582-3793

Date of Service: *(Please Print)* **Client's Name:**

Mailing Address: **City:**

Phone Number: **Zip Code:** **Sex:** (Circle One) **M** or **F**

Race: **Age:** **Ethnicity:** Hispanic / Not Hispanic

Date of Birth: **Parent/Guardian's Name:**

Payment Method (Check ALL that Apply)

Bill To: ☐ Client ☐ Insurance ☐ Pay at Time of Service ☐ Medicare ☐ Medicaid ☐ VFC

Payer information:

Member Name:_____**DOB**_____ **Relationship to Patient:**_____

Plan Name:_____ **I.D #:** _____ **Group#**_____

Secondary Insurance:_____ **Plan Name:** _____ **I.D.#:**_____

I authorize Mercer County Health Department to release service related information regarding the above mentioned person to third party payors and/or other health practitioners and to bill for service rendered to me if applicable. I request my payor to pay MCHD directly for services rendered to me. I understand that I am responsible for charges not covered by insurance.

Signature _____ Date _____

✓	IMMUNIZATIONS	DX	CPT	FEE
	DTAP	Z23	90700	
	Dtap/IPV (Kinrix)(Quadracel)	Z23	90696	
	Dtap/IPV/Hep B (Pediarix)	Z23	90723	
	Hep A Adult	Z23	90632	
	Hep A Child	Z23	90633	
	Hep B Adult	Z23	90746	
	Hep B Child	Z23	90744	
	Hep A/Hep B	Z23	90636	
	HIB	Z23	90648	
	HPV	Z23	90649	
	IPV	Z23	90713	
	MMR	Z23	90707	
	MMRV	Z23	90710	
	Meningococcal	Z23	90734	
	Pneumovax 23	Z23	90732	
	Prevnar 13 (Child)(Adult)	Z23	90670	
	Rotavirus	Z23	90681	
	Shingles (Admin Only)	Z23	90736	
	TD	Z23	90714	
	Tdap	Z23	90715	
	DTAP/IVP/Hib (Pentacel)	Z23	90698	
	Varicella	Z23	90716	

✓	LAB SERVICES	DX	CPT	FEE
	Hemoglobin (Finger stick)	Z00.129	85018	
	Lead Screening Child	Z00.129	36416	
	Pregnancy Testing-Negative	Z32.02	81025	
	Pregnancy Testing-Positive	Z32.01	81025	
	Hemoglobin A1C	Z00.00	83036	
	TB Skin Test-1 Step	Z11.1	86580	
	TB Skin Test-2 Step	Z11.1	86580	
	Capillary Blood Collection	Z00.129	36416	

✓	NURSING SERVICES	DX	CPT	FEE
	Developmental Testing	Z00.129	96110	
	Health Risk Pre-Natal	Z34.00	H1000	
	Health Risk Post-Natal(Modifer HD)	Z13.89	96127	
	Hearing Screening	Z01.10	92551	
	Injections (serum provided by client, i.e. B12)			
	Routine Infant 0 – 12 Mos. **NEW**	Z00.129	99381	
	Routine Child 1 – 4 Yrs **NEW**	Z00.129	99382	
	Routine Infant 0 – 12 Mos. **EST**	Z00.129	99391	
	Routine Child 1 – 4 Yrs. **EST**	Z00.129	99392	
	Topical Fluoride Varnish	Z41.8	D1206	
	Vision Screening Child	Z01.00	99173	
✓	**FLU SHOTS**	**DX**	**CPT**	**FEE**
	Pediatrics 6 – 35 months VFC	Z23	90685	
	3 years-18ys VFC	Z23	90686	
	High Dose 65+	Z23	90662	
	Pediatric 36 Mos>Adult PP	Z23	90686	

Total Charges for Services $_____

Co-Pay $_____

Additional Amount Paid $_____

BALANCE DUE $_____

☐ Cash ☐ Credit/Debit

☐ Check # _____

Nurse: _____

Comments: _____

MERCER COUNTY HEALTH DEPARTMENT ADMINISTRATION RECORD

(Please Circle one)

1. Has client been sick or been running a fever in the last 24 hours? Yes or No
2. Does client have any allergies to eggs, egg proteins, Thimerosal Gentamicin, Gelatin or Arginine? Yes or No

   If Yes, please explain:_____
3. Has client ever had any problems after receiving the flu vaccine in the past, other than mild flu like symptoms? If Yes, please explain:_____ Yes or No
4. Has the client ever been paralyzed by Guillain-Barre-Syndrome (GBS)? Yes or No
5. Does the client have any chronic medical conditions such as Diabetes, heart disease, kidney disease, metabolic disease, asthma or recurrent wheezing? Yes or No
6. Is your child receiving aspirin or aspiring containing therapy? Yes or No
7. If your child is 6 months – 9 years of age is this the first flu shot they have ever received? Yes or No

My signature gives permission for the Mercer County Health Department to give the influenza vaccine to the party listed on the form. My signature acknowledges receipt of the "Vaccine Information Sheet" for Influenza Vaccine. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to myself or to the party who accepts assignment. I hereby acknowledge that I received a copy of the "Notice of Privacy Practices" from the Health Department dated April 14, 2003. ***I AM RESPONSIBLE FOR PAYMENT OF THE VACCINE***

_____ _____

Signature **Date**

PLEASE COMPLETE THIS QUESTION:

The parent or guardian has stated that this child qualifies for vaccination though the Federal Vaccines of Children (VFC) program because he or she (circle one that applies)

(a) Is enrolled in Medicaid (b) Does not have health insurance (c) Is American Indian or Alaskan Native
(d) Has health insurance that does not pay for vaccines (underinsured)

The above eligibility states information was provided by me to my child's health care provider.

Do not write below this line

For Clinic/Office Use

Clinic/Office Address: MCHD **Date Given:** _____

VIS Date: 8/15/19 **VIS Given:** _____

Manufacturer: _____ **VFC or PP (Circle One)**

Lot #: _____ **Exp:** _____

Site of Injection: L or R

Signature of Vaccine Admin & Title: _____

Amount Paid for vaccine/administration: _____

Public Aid (RIN) #: _____