

Pneumococcal Pneumonia Vaccination Roster

Provider Name: _____

Billing Address: _____

Provider Billing Number: _____

Date of Service: _____

Patient Information

Claim Control Number	Health Insurance Claim Number	Last Name	First Name	MI	Address & Zip Code	DOB	Sex	Patient Signature/On File	PPV

Warning: Ask beneficiaries if they have been vaccinated with **PPV**.

- Rely on patients' memory to determine prior vaccination status.
- If patients are uncertain whether they have been vaccinated within the past five years, administer the vaccination.
- If patients are certain that they have been vaccinated within the past five years **do not revaccinate**.

Enter appropriate indicator in the PPV column. U = Unknown N = No Y = Yes

Must be legible or will be returned

Do not copy double sided

Revised 04/01/2003