FIRST COAST
SERVICE OPTIONS, INC.
WHEN EXPERIENCE COUNTS & QUALITY MATTERS

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

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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.

Reset Form

Print Form