



**RITE**<sup>™</sup>  
**AID**

Insurance Information required at time of COVID  
Immunization Administration

For some insurance plans this will be processed by your prescription plan, for others it will be covered by your medical plan. Both will be collected at this time to ensure accurate process completion.

Your Name: First \_\_\_\_\_ Last \_\_\_\_\_

Date of Birth \_\_\_\_\_

If over 65 or on Medicare your Medicare part A/B # \_\_\_\_\_

**Prescription Plan information:**

Name of Plan \_\_\_\_\_

Bin # \_\_\_\_\_

PCN # \_\_\_\_\_

Group # \_\_\_\_\_

ID # \_\_\_\_\_

Relationship circle one: Primary Spouse Child

If not Primary, please provide primary insured's name: \_\_\_\_\_

**Medical Plan information:**

Name of Plan \_\_\_\_\_

Group # \_\_\_\_\_

ID # \_\_\_\_\_

Processor control # if on card \_\_\_\_\_

Relationship circle one: Primary Spouse Child

If not Primary, please provide primary insured's name: \_\_\_\_\_