

ATTESTATION OF INSURANCE COVERAGE

Date _____

First Name _____ Last Name _____

For Offsite-Events ONLY:

Please provide your insurance information below.

Medical Benefits-

Insurance Carrier: _____ Patient ID: _____

Group: _____

Pharmacy Benefits-

Insurance Carrier: _____ Patient ID: _____

BIN: _____ PCN: _____ Group: _____

No Insurance Coverage

The Federal government wants to make sure that all individuals can receive the COVID-19 Vaccine regardless of health insurance status. Walmart is participating in the federal government's COVID-19 Uninsured Program. If you do not have insurance, we are asking you to confirm this fact to ensure we correctly file the claim for your vaccination service.

- I hereby declare that I do not have insurance coverage of any kind including, but not limited to Commercial Insurance, Medicare, or Medicaid.
- I understand that my lack of insurance does not prevent me from receiving the COVID-19 Vaccine.
- I understand that I will not be charged for the vaccine administration.
- I agree to inform my pharmacists if I am enrolled in Medicaid within the next 30 days.

Signature