Pneumococcal (PPV) Vaccine Roster Form

Provider Name	Date of Service (One date per roster)
National Provider Identifier (NPI)	

Warning: Beneficiaries must be asked if they have received a pneumococcal vaccination. Rely on patients' memory to determine prior vaccination status.

Patient Information (Please PRINT all elements clearly except the beneficiary's signature)

Medicare Number	Date of Birth (MM/DD/YYYY))	Sex: ☐ Male ☐ Female		
First Name	Last Name			MI
Address		City	State	Zip
Patient Signature				
Medicare Number	Date of Birth (MM/DD/YYYY))	Sex: ☐ Male ☐ Female		
First Name	Last Name			MI
Address		City	State	Zip
Patient Signature				
Medicare Number	Date of Birth (MM/DD/YYYY))	Sex: ☐ Male ☐ Female		
First Name	Last Name			MI
Address		City	State	Zip
Patient Signature				
Medicare Number	Date of Birth (MM/DD/YYYY))	Sex: ☐ Male ☐ Female		
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