*Northern Utah Scheduling Form

Community Nursing Services

CNS Cares

Immunization Clinic
772 East 700 South Suite #1A
Clearfield, UT 84015
Phone: 801-410-8778
www.cns-cares.org/immunizations-flu-shots

For administrative use only:
Clinic #: _____ Clinic Date: _____
Start Time: _____ End Time: _____
Nurses: _____ Clerks: _____
Confirmation: _____
Date: _____ Initials: _____
Date Received: _____
Additional Info: _____

FLU/COVID-19 CLINIC Scheduling Form

Email completed form to **Talea.Sedgwick@cns-cares.org** *(please allow 24-48 hours for a response)*

Organization Name: _____

Address: _____ City: _____ Zip: _____

Contact Person: _____ E-mail: _____

Phone: _____ Alternate Phone: _____

Alternate Contact: _____ E-mail: _____

Phone: _____ Alternate Phone: _____

Preferred Clinic Date: _____ Start Time: _____ End Time: _____

Alternate Clinic Date: _____ Start Time: _____ End Time: _____

Spanish Translation Needed? ☐ Yes ☐ No (we will do our best to send Spanish speaking staff, but it is not guaranteed)

Number of doses requested: Regular Flu Shots (age 6 mos+)_____ Sr Flu Shots (age 65+)_____

COVID-19 shots **reserved**: Adult (age 12+)_____ PEDS (age 6 mos-11 yrs) _____ **accurate COVID-19 #'s are required*

Payment Information

Community Nursing Services is contracted to directly bill the following insurance:

Aetna, Ameriben, Blue Cross *(no Blue Option)*, Cigna, Direct Care Aministrators, DMBA, Educators Mutual (EMI), GEHA, Meritain, Molina, Molina Marketplace, Oxford Health Plan, PEHP, Select Health, United Health Care, University of Utah, UMR, Tall Tree Administrators, Tricare, WISE Network, CHIP, Utah Medicaid, Medicare Part B, and most Medicare Advantage Plans.

Insurance card and photo ID must be presented at time of service.

I understand that any changes to my clinic must be made 10 days prior to the scheduled clinic date to avoid a $50 clinic fee AND that a $50 clinic fee may be charged if less than 25 shots are given at my clinic.

Signature required: _____

Bill Insurance? Yes ☐ No ☐ Which Insurance(s) will be billed? _____

Network: _____

Bill Company? Yes ☐ No ☐ Please specify whom company will pay for: _____

**A 5% discount will be applied if you wish to pay in full on the day of the clinic.* *(i.e.All employees, uninsured employees, all family members, etc.)*

Any Self-Pay? Yes ☐ No ☐ *(For those without insurance wanting to pay cash price.)*

Specific driving/parking instructions and additional information: _____

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