Health Promotion Affiliates Flu Request Form
Today's Date:____________

Company:____

3 Optional Dates:__________ __________ __________Time Requested:___________

Address:____________________________________ Site phone:_________________________

____________________________________ Fax:___________________

Site Contact:______________________________ E-mail:________________________

Estimate the number of hours you need for your clinic based on 20 shots per hour.

Please attach written directions with this fax. It saves us valuable time.

Were you Referred to Health Promotion Affiliates by your Health Insurance Co.?

Yes_____ No_____ If yes what Company?___________________________________

How many flu shots do you expect at your clinic?________

We need a very accurate count and will bring only that amount.
Please call 10 working days before the clinic to confirm the final count of flu shots.

Payment/Billing Information: Cost Center:________

A. Invoice for the balance of the flu clinic. The deposit will be subtracted from your invoice. ______

B. If employees pay, the company will collect the fee and send minimum deposit prior to the clinic.______

Billing Information: Company:____

Name:____

Address:____

Please note: reimbursement for travel is charged at the Federal Reimbursement Rate. If the mileage is greater than 100 miles round trip, travel time will be charged at $50.00 If between 150-199 round trip$ 75.00 If over 200 miles round trip; $100.00

Please send this completed form with deposit check to:

Att. Richard Rotondo, Health Promotion Affiliates, 661 Highland Ave., Needham, MA 02494
FEI# 043218267
Phone: (781) 449-2233 Fax:: (781) 449-7045 E-mail: mca.hpa@verizon.net