COVID-19 Vaccine Encounter Form

Date of Service: _____

Site# and Address: _____ **Provider:** _____

Patient Name: _____ **ID#:**_____ **Date of Birth:** _____

Address: _____ **City, State, Zip:** _____

Sex: _____ **Race:** _____ **Ethnicity:** _____ **Email Address:** _____

Product Name: COVID 19 Vaccine **Mcf:** Pfizer-BioNTech **Lot#:** _____
NDC#: 59267-1000-1 **Exp Date:** _____

Time Vaccine Administered: _____ **Vaccine Administered by (Print Name):** _____

CPT Codes

Covid-19 Vaccination (Pfizer)	91300	____	
Administration FIRST Dose	0001A	____	Date of FIRST Dose: _____
Administration SECOND Dose	0002A	____	Date of SECOND Dose: _____
Administration THIRD Dose	0003A	____	

Diagnosis Code

Encounter for Immunization Z23 ____

NOTES:

Patient here today for Covid-19 Vaccine. Patient given vaccine IM in _____arm. Patient tolerated procedure well after waiting 15 minutes.

provider signature and credentials

Was vaccine done at time of visit with provider? Yes _____ or No _____.
If Yes, please initial _____.