GALEN
PHARMACY

Galen Pharmacy, LLC COVID-19 Vaccine
Uninsured Attestation

I, ________________________________, confirm that I am uninsured and do not currently have any form of health care coverage as of the date I received either dose (e.g. first or second) of the COVID-19 vaccine. If I do become insured before/during any of the administration dates, I will let Galen Pharmacy, LLC, know.

My signature below also indicates that I allow Galen Pharmacy, LLC, to submit a vaccine administration claim on my behalf to HRSA (Heath Resources & Services Administration). I am aware that billing HRSA will not make me responsible for any type of payment related to COVID-19 vaccine administration.

Signature: __________________________________ Date: _______________________________

Patient Information Necessary for HRSA Claim	
First and Last Name	
Date of Birth	
Gender	
SSN and State of Residence	
Full Home Address	

TO BE COMPLETED BY PERSON ADMINISTERING VACCINE

Date of First COVID-19 Vaccine Dose: _________ Signature: _______________________________

Date of Second COVID-19 Vaccine Dose: _________ Signature: _______________________________