

# Flu Shot Clinic



Office: 1-800-764-0418

KMM provides flu shots as a **company-paid program**. **NO INSURANCE FILING / USAGE**. Minimum participation requirement is **10 employees** guaranteed. Can be scheduled with a Health & Wellness Fair or separately.

**Cost:** (Please check where applicable)

- Guaranteed 10 employee minimum PER location: \$34 per flu shot**
- 11-50 employees PER location \$32 per flu shot**
- 51 and up employees PER location: \$30 per flu shot**
- Individual (employee paid / employee family member paying): \$35 per flu shot**

- **Pricing is subject to change. Please contact KMM.**
- **If minimum is not met per location, a \$125 travel fee will be charged.**

Employees are to RSVP their time: *(If with KMM, we take care of all scheduling. Company is responsible for sending out friendly reminder)*

\_\_\_\_\_ Direct with KMM On-line                      \_\_\_\_\_ Direct with Company

## Scheduling

Requesting Date (Please include DAY) / & Time Frame: \_\_\_\_\_

Address Where Flu Shot Clinic will be held at: \_\_\_\_\_

Location of Flu Shot Clinic: *(For example: Cafeteria, Gym, Break Room):* \_\_\_\_\_

Billing Address & Responsible Party: (Please print)

Name of Company: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Title: \_\_\_\_\_

Billing Address: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ ext: \_\_\_\_\_ Fax: \_\_\_\_\_

Email Address: \_\_\_\_\_

I am authorizing Kaiser Medical Management to provide \_\_\_\_\_ *Company Name* \_\_\_\_\_ a Flu Shot Clinic for its' employees / members and have reviewed and understand cost. I understand that all employees will have to sign a release waiver showing they are requesting to have a flu shot and have read and understand the flu shot vaccination consent form and that the Company, KMM, nor Administer is responsible for any liability. KMM will invoice for payment within 24-hours after Flu Shot Clinic date. Payment is due upon receipt. I understand minimums must be met or a \$125 travel fee will apply. I understand no additional discounts apply. I understand NO INSURANCE FILING/USAGE will be done by KMM.

Authorized Signature Approving Flu Shot Clinic: \_\_\_\_\_

Authorized Person's Name in Print: \_\_\_\_\_

Date: \_\_\_\_\_

Flu Shot Clinic  
45-Day Notice Required / 60-Day Notice Required September—November  
FAX TO 1-888-688-4176  
www.kaisermedicalmanagement.com  
You will be notified by email that we received fax.