meridianhealth
A WellCare Company
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Adolescent Immunization Exclusion Form

Member Name: _____

Member ID#: _____

Date of Birth: _____

This member has had a contraindication (anaphylactic reaction to the vaccine or its components) for the Tdap and/or Meningococcal vaccine(s) before their 13th birthday.

Tdap Vaccine
Date of Contraindication: _____

Meningococcal Vaccine
Date of Contraindication: _____

Medical record documentation must be attached to exclude the member.

Provider Signature: _____ Date: _____

Please fax the completed form to 312-508-7213.

Thank you for your cooperation in this important matter. Please call the MeridianHealth Quality Improvement department at **312-705-2900** if you have any questions.