APPLICATION AND CLAIM FOR BIOLOGICALS

State Form 43918 (R / 11-97)
Approved by State Board of Accounts 1990

STATE OF INDIANA
STATE DEPARTMENT OF HEALTH

INSTRUCTIONS:

1. Indiana code 16-41-19-2 requires counties, cities, and towns to supply certain biological products to persons who are financially unable to pay for them, upon application by a licensed physician.
2. The biological products covered by this law are diphtheria antitoxin, tetanus antitoxin, and rabies vaccines. Any dealer may supply the biologicals. Physician / treatment fees are not reimbursable under IC 16-41-19.
3. BLANK FORMS are supplied by the State Department of Health to local health officers who, in turn, supply physicians on request.
4. Prepare a separate form for each patient.
5. COMPLETED FORMS are submitted by the physician to the local health officer. Local health officers will make a copy or extract information (IC 16-41-19-8), sign the form, and immediately forward the original to the agency directed by ISDH guidelines.

APPLICATION (*Physician fill in*)

Date (*month, day, year*)

Name of patient	Age	Sex	Weight

Address (*number and street, city, state, ZIP code*)

Township of residence	County of residence

If patient is a child, name of parent or guardian

Biological applied for:

- ☐ Diptheria Antitoxin
- ☐ Tetanus Antitoxin
- ☐ Tetanus Immunoglobulin (*Human*)
- ☐ Rabies Immunoglobulin (*Human*)
- ☐ Rabies Vaccine, _____ doses

Physician's Statutory Affirmation: "I solemnly affirm that the free biologicals applied for will be administered to the person named above, and it is my belief after inquiry that the person is financially unable to pay for them."

Signature of physician	Telephone number
	( )

Vendor's Claim: This form, when properly completed and signed below by the physician, is a legal claim for the market price of the biologicals furnished.

Signature of Claimant / Vendor (*Pharmacist, Hospital Administrator, etc.*)

Address (*number and street, city, state, ZIP code*)

	Telephone number
	( )

	Total Doses		Price Per Unit Dose	Total Price of Biologicals
Diptheria Antitoxin	_____	U.	_____	_____
Tetanus Antitoxin	_____	U.	_____	_____
Tetanus Immunoglobulin	_____	U.	_____	_____
Rabies Immunoglobulin	_____	ml.	_____	_____
Rabies Vaccine	_____	ml.	_____	_____

I certify the foregoing account is just and correct, the amount claimed is legally due, after allowing all just credits, and no part of the same has been paid. (IC 5-11-10-1; IC 16-41-19-6)

Signature of Claimant / Vendor	Date (*month, day, year*)

Local Health Officer: Reviewed and copy retained.

By:

Check or
Warrant No. _____
Date

APPROVED FOR PAYMENT _____

_____
Signature

_____
County / Township / City

I have examined the within claim and hereby certify as follows:

That it is in proper form.

That it is duly authenticated as required by law.

That it is based upon statutory authority.

That it is apparently (*correct, incorrect*) in the sum of

$ _____

_____
Disbursing Officer

BIOLOGICALS CLAIM
(Indiana Code 16-41-19)

PAID TO _____

AMOUNT _____

PAID FROM _____

_____

Local Reproduction is Authorized.