Medicare Part D Vaccine and Administration (Injection) Claim Form

This claim form is for reimbursement of covered Part D vaccines and their administration (injection). Please consult your Evidence of Coverage for specific coverage information.

Instructions for completing this form are located on the back of this form.
Please review the instructions prior to completing this form.

Part 1- Please complete Part 1 fully to ensure proper reimbursement of your claim.
Please type or print clearly.

Plan Participant Information (Please use a separate claim form for each cardholder)

ID Number:	Name:	Date of Birth:
Gender: ❑ Male ❑ Female		
Address		Apt .
City	State	Zip Code
Telephone (include area code)		

Fraud Prevention Regulation: I certify that I have received the medicine described herein and that I am the plan participant named and am eligible for prescription benefits. I also certify that the medicine received is not for treatment of an on-the-job injury or covered under another benefit plan. I authorize release of all information pertaining to this claim to the pharmacy benefit manager, the insurance underwriter; sponsor; and/or policyholder. I certify that all the information entered on this form is correct. By signing this form, I certify that I have no intent to defraud the insurer and this claim does not contain or conceal any false or misleading information. I understand that false or misleading statements may be subject to criminal and/or civil penalty.

X _____

Signature required to acknowledge understanding of the statement above. Date

Part 2 - Remember to include original pharmacy receipts. Keep copies for your records.

Dispensing Pharmacy Information (If purchased at a pharmacy, have pharmacy complete.)

Pharmacy Name		
National Provider ID Number		
NCPDP Provider ID Number		
Telephone (include area code)		
Address		
City	State	Zip Code

This claim is for:
(Please check ✓ all that apply.)
- ☐ The vaccine
- ☐ The administration (injection) of vaccine.
- ☐ Both the vaccine and the administration

Part 3 - Remember to include original doctor's office receipts. Keep copies for your records.

Physician Information (If obtained from or administered at doctor's office, have office complete.)

Physician Name		
National Provider ID Number		
Telephone (include area code)		
Address		
City	State	Zip Code

This claim is for:
(Please check ✓ all that apply.)
- ☐ The vaccine
- ☐ The administration (injection) of vaccine.
- ☐ Both the vaccine and the administration

Part 4 - Remember to include original receipts. Original receipts must contain required information.
This form may be used for Part D Vaccines, some examples are listed below. Keep copies for your records.

Vaccine Prescription Information(Complete if vaccine was obtained or administered in a pharmacy or physician's office)

Required Information:

- ✓ **Please obtain information from your physician or pharmacy if it is not provided as part of your receipt or bill.**
- ✓ **You must enclose the receipt(s) for the vaccine and/or administration with this form.**
- ✓ **Complete one line for each vaccine. Be sure the charges for the vaccine(s) and the administration(s) are separated in the table below so we can reimburse you properly.**

	RX # - if received at pharmacy	Drug Name	11 Digit NDC #	Quantity	Date Filled	Date Administered	Vaccine Charge	Admin. Fee
☐	**Example**	**Zostavax**						
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How to complete this form and where to mail :

Complete all plan participant information in Part 1 on reverse side.

- The Plan Participant ID number can be found on your ID card.
- Sign and date the prescription claim form in the spaces provided. Your signature certifies that the information is correct and complete.
- Please make a copy of all documents and receipts before you send them to you pharmacy benefit manager. No documents will be returned.
- If you have questions, please call your pharmacy benefit manager at the number listed on your ID card.

Mail To: **Independence Blue Cross**
PO Box 650287
Dallas, TX 75265

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