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.

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Part 1- Please	complete Part 1 fully				claim.		
			type or print clear	y.			
Plan	ID Number:	Name:			Date of Birth:		
Participant							
Information							
(Please use a		☐ Female					
separate	Address				Apt.		
claim form	- C'			a	7: 0 1		
for each	City			State	Zip Code		
cardholder)	Telephone (include a	rea code)					
	Telephone (include area code) Fraud Prevention Regulation: I certify that I have received the medicine described herein and						
					nedicine described herein and on benefits. I also certify that the		
	medicine received is no	ot for treatme	ent of an on-the-iol	b injury or co	overed under another benefit		
	plan. I authorize release	e of all information	mation pertaining	to this claim	to the pharmacy benefit		
	manager, the insurance	underwriter	; sponsor; and/or p	olicyholder.	I certify that all the information		
	entered on this form is	correct. By s	signing this form, l	certify that l	have no intent to defraud the		
	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.						
	understand that raise of	imsicading	statements may be	subject to ci	miniar and/or civil penaity.		
	X						
	Signature required to a	acknowledge	understanding of	the statemen	t above. Date		
Part 2 - Reme							
	mber to include origi				ur records.		
Dispensing				copies for yo	ur records. This claim is for:		
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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 Please obtain information from your physician or phase in the property of the prop

obtained or administered in a pharmacy or physician's office)

✓ 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						

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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