

Instructions Read carefully before completing this form.

Sections 1–7 must be completely filled out or your reimbursement will be delayed:

Section 1: Member/Subscriber information must include your Member ID from your MVP ID card.

Sections 2 & 3: You will only fill out **one** of these 2 sections depending on where you received your vaccine. If you received your vaccine at a pharmacy, fill out Section 2. If you received your vaccine at your doctor’s office or local Department of Health, fill out Section 3.

Section 4: After completing this form, you must read the acknowledgment carefully, then sign and date this form.

Section 5: You must check a box to identify where you obtained your vaccine. If you received your vaccine at your doctor’s office or at the local Department of Health, please check box E.

Section 6: You must check a box to indicate if you are submitting for reimbursement of the vaccine, the administration of the vaccine, or both.

Section 7: You must select one of the vaccines listed below **and** fill in all of the requested information. Please make sure the charges for the vaccine and the administration are listed separately. If you don’t have a valid 11-digit NDC#, or the NDC you have isn’t listed, call MVP for help.

Return this completed form and the receipt(s) from your vaccine to: Medco Health Solutions, Inc., P.O. Box 14718, Lexington, KY 40512.

7. Vaccine Rx Information (Required Information. Please submit one form per vaccine.)

Please check the appropriate box for the vaccine you have received. If the vaccine you received does not appear below, please fill in the vaccine name, NDC number, quantity, vaccine charge, and administration fee in the blank space provided below.

				Rx#			
	Brand Name	Valid 11-digit NDC#	Quantity	Days Supply	Date Filled	Vaccine Charge	Vaccine Admin. Fee
<input type="checkbox"/>	ZOSTAVAX*	00006496300	1 Vial	1			
<input type="checkbox"/>	ZOSTAVAX*	00006496341	1 Vial	1			
<input type="checkbox"/>	ZOSTAVAX*	54868570300	1 Vial	1			
<input type="checkbox"/>	DECAVAC	49281029183	0.5 mL	1			
<input type="checkbox"/>	DECAVAC	49281029110	0.5 mL	1			
<input type="checkbox"/>	TETANUS TOXOID	49281082010	0.5 mL	1			
<input type="checkbox"/>	TETANUS-DIPHThERIA TOXOIDS	17478013101	0.5 mL	1			
<input type="checkbox"/>	TETANUS-DIPHThERIA TOXOIDS	14362011103	0.5 mL	1			
<input type="checkbox"/>	TETANUS-DIPHThERIA TOXOIDS	14362011101	0.5 mL	1			
<input type="checkbox"/>	ADACEL	49281040010	0.5 mL	1			
<input type="checkbox"/>	ADACEL	49281040015	0.5 mL	1			
<input type="checkbox"/>	TWINRIX	58160081546	1 mL	1			
<input type="checkbox"/>	HAVRIX	58160082611	1 mL	1			
<input type="checkbox"/>	HAVRIX	58160082646	1 mL	1			
<input type="checkbox"/>	RECOMBIVAX HB	00006498100	1 mL	1			
<input type="checkbox"/>	BOOSTRIX	58160084211	0.5 mL	1			
<input type="checkbox"/>	BOOSTRIX	58160084251	0.5 mL	1			
<input type="checkbox"/>							

*Zostavax is only covered for members aged 60 and over.

