

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. Please review the instructions prior to completing this form.

1. Member / Subscriber Information

See your prescription drug ID card.

Group No.

Member ID

Member Name (First, Last) _____

Street Address _____

City _____ State _____ Zip _____

Date of Birth (MM/DD/YYYY)

2. Dispensing Pharmacy Information

(Applicable only if the vaccine was purchased at a pharmacy)

Name of Pharmacy _____

Street Address _____

City _____ State _____ Zip _____

Telephone (include area code)

NCPDP Provider ID Number: _____

National Provider ID Number: _____

3. Prescribing Physician Information

(Complete if vaccine was obtained or administered in a physician's office)

Name of Physician: _____

National Provider ID Number: _____

4. Acknowledgment

I certify that the medication described on this form was received for use by the patient listed above, and that I (or the patient, if not myself) am eligible for prescription drug benefits. I also certify that the medication received was not for an on-the-job injury or covered under another benefit plan. I recognize that reimbursement will be paid directly to me, and that assignment of these benefits to a pharmacy or other party is void.

Signature of Member

Visit us online anytime at www.mvphealthcare.com.

5. Does this claim qualify for coverage?

Please check the box that applies to your situation. **If you received a vaccine at your doctor's office or local Department of Health, please check box E.**

- A.** I traveled outside my plan's service area and required a vaccination.
- B.** I was unable to obtain my vaccine in a timely manner within my service area (there was no network pharmacy within a reasonable driving distance that provides 24 / 7 service).
- C.** My vaccine is not stocked regularly at an accessible network or mail-order pharmacy.
- D.** My vaccine was dispensed from an emergency department, provider-based clinic, outpatient surgery facility, or other outpatient setting.
- E.** I received a vaccine at my doctor's office or at my local Department of Health.
- F.** I was evacuated or displaced from my residence due to a State or Federally declared disaster or health emergency.

**** You must enclose the receipt(s) for your vaccine with this form.**

6. Claim Information

Please check all that apply.

This claim is for:

- The vaccine
- Administration (injection) of the vaccine
- Both the vaccine and the administration (injection) of the vaccine

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 Medco 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.

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.

| | Brand Name | Valid 11-digit NDC# | Quantity | Rx# | 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"/> | TETANUS TOXOID | 49281082010 | 0.5 mL | | 1 | | | |
| <input type="checkbox"/> | TETANUS-DIPHTHERIA TOXOIDS | 14362011103 | 0.5 mL | | 1 | | | |
| <input type="checkbox"/> | ENGERIX-B | 58160082111 | 1 mL | | 1 | | | |
| <input type="checkbox"/> | ENGERIX-B | 58160082148 | 1 mL | | 1 | | | |
| <input type="checkbox"/> | M-M-R II VACCINE | 00006468100 | 1 mL | | 1 | | | |
| <input type="checkbox"/> | TWINRIX | 58160081546 | 1 mL | | 1 | | | |
| <input type="checkbox"/> | HAVRIX | 58160082611 | 1 mL | | 1 | | | |
| <input type="checkbox"/> | HAVRIX | 58160082648 | 1 mL | | 1 | | | |
| <input type="checkbox"/> | RECOMBIVAX HB | 00006499500 | 1 mL | | 1 | | | |
| <input type="checkbox"/> | VAQTA | 00006484100 | 1 mL | | 1 | | | |
| <input type="checkbox"/> | VARIVAX VACCINE | 00006482700 | 1 Vial | | 1 | | | |
| <input type="checkbox"/> | GARDASIL† | 00006404500 | 0.5 mL | | 1 | | | |
| <input type="checkbox"/> | | | | | | | | |

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

†Gardasil is only covered for members between the ages of 9 and 26.

