Vaccine and Administration (Injection) Claim Form

selecthealth ADVANTAGE

This claim form is for reimbursement of covered Part D vaccines and their administration (injection). Please consult our Drug List at **selecthealth.org/medicare** or your Evidence of Coverage for specific coverage information.

Instructions

1. Please complete all information. An incomplete form may delay your reimbursement.
2. Please make sure the charges for the vaccine and the administration (injection) are listed separately, otherwise we cannot properly reimburse you.
3. Your pharmacist or doctor's office should be able to provide some of the necessary information if it was not already provided as part of your claim or bill.
4. You should enclose the receipt(s) for your vaccine with this form.
5. After completing this form, the plan member should read the acknowledgement carefully, then sign and date this form.
6. Return the completed form and receipt(s) to:
   SelectHealth Advantage
   Attn: Pharmacy Services
   PO Box 30196
   Salt Lake City, UT 84130
7. Some vaccines are covered under Part B (example: flu, PNEUMOVAX). Only vaccine claims covered under Part D should be submitted on this form.

Member / Subscriber Information

Member ID Number_____
(See your SelectHealth Advantage Member ID Card.)

Member Name (First, Last) _____

Street Address _____

City _____ State ____ ZIP_____

Date of Birth _____/_____/_____
MM DD YYYY

Member's Ph# (including area code) _____

Dispensing Pharmacy Information

(Complete this section if you received the vaccination(s) at a pharmacy.)

Name of Pharmacy _____

Street Address _____

City _____ State _____ ZIP _____

Pharmacy's Ph# (including area code) _____

NCPDP Provider ID# _____

National Provider ID# _____

Does this claim qualify for coverage?

You may submit a claim for Part D-covered medication dispensed by an out-of-network pharmacy only for the reasons listed below. Please check the box that applies to your situation:

- ❑ I received a vaccine at my doctor's office. (Be sure to include the receipt from the physician and complete vaccine Rx information section on the back of this form.)
- ❑ I traveled outside my plan's service area and ran out of (or lost) my medication/I became ill and could not access a network pharmacy
- ❑ I was unable to obtain my medication in a timely manner within my service area
- ❑ My medication is not stocked regularly at an accessible network pharmacy
- ❑ My medication was dispensed from an emergency department, provider-based clinic, outpatient surgery facility, or other outpatient setting
- ❑ I was evacuated or displaced from my residence due to a State, federal or other public disaster declaration

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

Prescribing Physician Information

(Complete this section if you received the vaccination(s) at a provider's office.)

Name of Provider _____National Provider ID# _____

Provider Phone Number (including area code) _____

Vaccine Rx Information

(Remember to enclose original receipts that contain required information. Keep copies for your records.) Please complete one line for each vaccine. Be sure the charges for the vaccine(s) and administration(s) are separated in the table below so we may reimburse you properly.

				Rx#			
	Brand Name	Valid 11-digit NDC#	Quantity	Days' Supply	Date Filled	Vaccine Charge	Vaccine Admin. Fee
❑							
❑							
❑							
❑							
❑							
❑							
❑							
❑							
❑							
❑							

Acknowledgement

I certify that the medication(s) described on this form was/were 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 _____ Date _____

Any person who knowingly and with intent to defraud, injure or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent insurance act which is a crime and may be subject to criminal or civil penalties, including fines and/or denial of benefits.

Questions? Call Member Services toll-free at **855-442-9900** during the following dates and times:

- **October 1 to March 31:** Weekdays 7:00 a.m. to 8:00 p.m., Saturday and Sunday 8:00 a.m. to 8:00 p.m.
- **April 1 to September 30:** Weekdays 7:00 a.m. to 8:00 p.m., Saturday 9:00 a.m. to 2:00 p.m., closed Sunday

Outside of these hours of operation, please leave a message and your call will be returned within one business day. TTY users, please call 711.

SelectHealth is an HMO, HMO-SNP plan sponsor with a Medicare contract. Enrollment in SelectHealth Advantage depends on contract renewal.

SelectHealth complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-442-9900 (TTY: 711).
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-442-9900 (TTY：711).

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