Flu Shot Reimbursement Form

UPMC Health Plan

Please submit this form ONLY if flu shot was paid for by member(s) and/or subscriber.

Subscriber: Please complete this section for the subscriber, whether or not he or she received a flu shot.

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Member: Complete this section in its entirety for each person who received a flu shot under the above subscriber's coverage, including the subscriber. If more than two members received a flu shot, you can photocopy this form, download additional reimbursement forms at www.upmchealthplan.com, or obtain additional copies by calling the number that is on the back of your member ID card.

Member 1

Member ID# _____

Name _____

Date of Birth _____

Cost of Flu Shot _____

Date Received _____

Facility Where Received _____

Member 2

Member ID# _____

Name _____

Date of Birth _____

Cost of Flu Shot _____

Date Received _____

Facility Where Received _____

Subscriber Signature (Required) _____

I have paid for my flu shot(s) out-of-pocket and I am requesting reimbursement for that cost.

For your reimbursement, please mail this form and a copy of your flu shot receipt(s) to:

Attention: Special Processing
UPMC Health Plan
P.O. Box 2966
Pittsburgh, PA 15230

UPMC_11_525
CMN11-0719-5

FLU ST REIMB FM C20110520-12 (BAM) 08/17/11 xx xx