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.

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 ☐☐ ☐☐ ☐☐☐☐ (M M D D Y Y Y Y)

Dispensing Pharmacy Information

(Not applicable if the vaccine was not purchased at a pharmacy)

Name of Pharmacy

Street Address

City State ☐☐ ZIP ☐☐☐☐☐

Telephone (include area code) ☐☐☐ ☐☐☐ ☐☐☐☐

NCPDP Provider ID Number:

National Provider ID Number:

Prescribing Physician Information

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

Name of Physician

National Provider ID Number:

Acknowledgment

I certify that the medication(s) 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.

X

Signature of Member

Visit us online anytime at **www.medco.com/medd**.

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Does this claim qualify for coverage?

You may submit a claim for Part D–covered medication dispensed by a nonparticipating pharmacy only for the reasons listed below.

Please check the box that applies to your situation:

- ☐ **A.** 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.
- ☐ **B.** I was unable to obtain my medication 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 medication is not stocked regularly at an accessible network or mail-order pharmacy.
- ☐ **D.** My medication 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. (Be sure to include the receipt from the physician and complete Vaccine Rx Information section on back.)
- ☐ **F.** I was evacuated or displaced from my residence due to a State- or Federally declared disaster or health emergency.

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.

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: **Medco Health Solutions, Inc., P.O. Box 14718, Lexington, KY 40512.**
7. Some vaccines are covered under Part B (example: flu, PNEUMOVAX). Only vaccine claims covered under Part D should be submitted on this form.

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**
☐	**ZOSTAVAX***	**00006496300**	1	1			
☐	**ZOSTAVAX***	**00006496341**	1	1			
☐	**ZOSTAVAX***	**54868570300**	1	1			
☐	DECAVAC	49281029183	0.5	1			
☐	TETANUS TOXOID	49281082010	0.5	1			
☐	ENGERIX-B	58160085701	1	1			
☐	M-M-R II VACCINE	00006468100	1	1			
☐	TWINRIX	58160085046	1	1			
☐	HAVRIX	58160083501	1	1			
☐	HAVRIX	58160083511	1	1			
☐	ENGERIX-B	58160085711	1	1			
☐	RECOMBIVAX HB	00006499500	1	1			
☐	VAQTA	00006484100	1	1			
☐	VARIVAX VACCINE	00006482700	1	1			
☐	GARDASIL†	00006404500	0.5	1			
☐				1			

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 imprisonment, or denial of benefits.

California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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

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

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