GB-79
R 1010

OGB Flu Vaccination Claim Form

State of Louisiana - Office of Group Benefits
P.O. Box 44036, Baton Rouge, LA 70804

IMPORTANT!! PLEASE READ:

1. This form is for use by **PPO plan members ONLY**, for claims for flu vaccinations ***administered at pharmacies ONLY.***
2. Complete this form and submit an original receipt (not a cash register receipt) for administration of influenza vaccine with this claim form. **Do not use your general-purpose flexible spending arrangement (GPFSA) card to pay for the vaccine.**
3. The receipt should include *the date administered, the cost, the vaccine name, the name of the person who received the shot and the pharmacist who administered the shot.*
4. **Sign** and date the form. Mail the form and the original receipt to the above address. Visit OGB's website (www.groupbenefits.org) under the PPO health plan on how to receive reimbursement using the OGB GPFSA card.

PLEASE PRINT OR TYPE ALL INFORMATION

SECTION 1: Pharmacy Information

Name of pharmacy that administered flu vaccination

City State Area Code & Phone

SECTION 2: Plan Member Information

Plan Member's Last Name First Name Middle Initial

Social Security Number Daytime Area Code & Phone

Address

City State Zip Code

This claim is for: ☐ Plan Member ☐ Dependent

SECTION 3: Dependent Information

Dependent's Last Name First Name Middle Initial

Birthdate Check one: ☐ Spouse ☐ Child ☐ Stepchild ☐ Other ____________

SECTION 4: Other Information

Is patient covered by another group health plan or Medicare? ☐ Yes ☐ No

Health plan name

Address Area Code & Phone

City State Zip Code

Policy Number Name of Policy Holder

SECTION 5: Signature Authorization

I hereby authorize any physician, hospital or other medically related facility, insurance company, or other organization, institution or person to release to the Office of Group Benefits, its utilization review firm or its representative, any records or information relating to my claim. I authorize the Office of Group Benefits to release to and receive such medical information from its utilization review firm. Such medical information may be released in writing or by telephone. A copy of this authorization shall be considered as effective and as valid as the original.

______________________________ Plan Member's Signature

__ __ / __ __ / __ __ __ __ Date

______________________________ Patient's Signature (if different from plan member)

__ __ / __ __ / __ __ __ __ Date