BlueCross BlueShield of Louisiana

An independent licensee of the Blue Cross and Blue Shield Association.

Flu Vaccination Claim Form
(for OGB plan members)

Blue Cross and Blue Shield of Louisiana
P.O. Box 98029, Baton Rouge, LA 70898-9029

IMPORTANT!! PLEASE READ:

1. This form is for use by **plan members ONLY**, for claims not filed by network providers.
2. Complete this form and submit an original receipt (not a cash register receipt) for administration of influenza vaccine with this claim form. **If you have an OGB general-purpose flexible spending arrangement (GPFSA) card, do not use it 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 medical provider or pharmacist who administered the shot.
4. **Sign** and date the form. Mail the form and the original receipt to the above address.
5. For details on how to receive reimbursement from your GPFSA for remaining out-of-pocket costs after your claim has been processed by your health plan, visit OGB's website **(www.groupbenefits.org)** and click on the flu information link.

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 _____

Member ID or 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

_____ _____
Plan Member's Signature Date

_____ _____
Patient's Signature (if different from plan member) Date