Flu Shot Reimbursement Form

For instructions on how to fill out this form, please see "How to submit your claim" on page 2.	"I paid out of pocket and am requesting reimbursement for medical services." **You must include your original receipt and your proof of payment with this claim form.

MEMBER INFORMATION

Patient Name:	**Date of Birth:**
MVP Member # (located on your MVP ID Card):	
Address:	**City/State/Zip:**
Phone Number:	

PROVIDER/BILLING INFORMATION

Provider Name: PAYSUB	
Address:	
Phone:	
NPI Number: 1999999984	**Tax ID: 199999998**

HCPCS or CPT code (please check appropriate box):

	Drug Name	HCPCS/ CPT Code	Dosage	Package Quantity	Administration Code
□	Afluria	90656	0.5 mL	10	G0008
□	Afluria	Q2035	0.5 mL	1	G0008
□	Fluarix	90656	0.5 mL	10	G0008
□	Flulaval	Q2036	0.5 mL	1	G0008
□	FluMist	90660	0.2 mL	10	G0008
□	Fluvirin	Q2037	0.5 mL	1	G0008
□	Fluzone	90657	0.25 mL	1	G0008
□	Fluzone	Q2038	0.5 mL	1	G0008
□	Fluzone (Preservative Free)	90656	0.5 mL	10	G0008
□	Fluzone High-Dose	90662	0.5 mL	10	G0008
□	Fluzone Intradermal	90654	0.1 mL	10	G0008

Diagnosis code (please check just one box based on date flu vaccine was given):

☐ **V04.81 – Flu Vaccination- Visits 9/30/15 and before ONLY**

☐ **Z23- Flu Vaccination- Visits 10/1/15 and After ONLY**

Place of Service (please check appropriate box):

☐ **01 - Pharmacy**

☐ **11 - Doctor's Office**

☐ **22 - Hospital Clinic**

☐ **60 - Mass Immunization Center/Department of Health**

Date of Service:	**Total Charges: $**

I CERTIFY THAT THE ABOVE STATEMENTS ARE CORRECT

Patient's Signature:	**Date:**

How to submit your claim:

If you have any questions about completing the claim form or benefits covered under your contract, please contact us at the number listed on your MVP identification card.

Mail completed claims to:

Claims Submission
MVP Health Care
P.O. Box 2207
Schenectady, NY 12301

In order to process your claim promptly, please refer to the following guidelines to ensure that all necessary information is included:

A. A separate claim form must accompany each receipt. Original bills must be submitted with your claim form. Keep copies for your own records.

B. Receipts must include:
   - Name and address (on letterhead) of the provider of service or supply (doctor, pharmacy, etc.).
   - Patient's full name and MVP member number (located on your MVP ID card).
   - HCPCS or CPT code for the type of service (see HCPCS/CPT code chart on Page 1).
   - Place of service (pharmacy, doctor's office, hospital).
   - Date of service and total charge for the vaccine and administration.
   - Diagnosis code (the reason you received your vaccine). There are different codes for flu shots given 9/30/15 and before and for flu shots given 10/1/15 and after.

C. Cancelled checks, money orders, credit card vouchers and personal lists of services or bills stating only 'balance forward' are not acceptable as substitutes for bills.

D. If another insurance carrier had made payment on this service, an explanation of benefits from the other insurance carrier must be attached in order for MVP to pay the claim as a secondary payer.