NATIONAL PHARMACEUTICAL SERVICES

P.O. Box 407, Boys Town, NE 68010

MEDICARE PART D VACCINE AND ADMINISTRATION (INJECTION) CLAIM FORM

This claim form is for reimbursement of covered Part D vaccines and their administration (injection). Please consult your Formulary or Evidence of Coverage for specific coverage information.

INSTRUCTIONS:

- Please complete all information; an incomplete form may delay the reimbursement process.
- Your pharmacist or doctor's office can provide some of the necessary information if it is not already part of your claim or bill.
- Please make sure the charges for the vaccine and its administration are listed separately for proper reimbursement.
- You must enclose the receipt(s) for your vaccine and administration with this form.
- Some vaccines are covered under Part B; only vaccine claims covered under Part D should be submitted on this form.
- Keep a copy of the completed form for your records. Consult your Formulary or Evidence of Coverage for specific coverage information.

Member Information (See your prescription ID card) Please type or print clearly.		
Group #		
Member ID #		
Name (First, Last)		
City	State	Zip
Date of Birth:		
Gender: ❑ Male ❑ Female		
Telephone (include area code)		

Does this claim qualify for coverage?

You may submit a claim for Part D-covered medication dispensed by a non-participating pharmacy only for the reasons listed below (please check the box that applies to your claim):

❑ I received a vaccine at my doctor's office.

❑ I traveled outside my plan's service area and ran out of my medication, lost my medication, or became ill and needed medication and could not access a network pharmacy.

❑ I was unable to obtain my medication in a timely manner within my plan's service area because there was no network pharmacy within a reasonable driving distance that provided 24 hours a day, 7 days a week service.

❑ I was unable to obtain my medication in a timely manner because my medication is not regularly stocked at an accessible retail or mail-order network pharmacy.

❑ I was provided medication dispensed from an out-of-network institution-based pharmacy as a patient in an emergency department, provider-based clinic, outpatient surgery facility, or other outpatient setting.

❑ I was unable to obtain my medication at a network pharmacy because I was evacuated or displaced from my place of residence due to a state, federal, or other public disaster declaration.

Fraud Prevention Regulation:

I certify that I have received the medicine described in this document and that I am the beneficiary named and am eligible for prescription benefits. I also certify that the medicine received is not for treatment of an on-the-job injury or covered under another benefit plan. I authorize release of all information pertaining to this claim to NPS, the prescription benefits manager, the insurance underwriter, sponsor, and/or policyholder. By signing this form, I certify that all the information entered is correct, that I have no intent to defraud the insurer, and this claim does not contain or conceal any false or misleading information which would make me subject to criminal and/or civil penalty.

Signature required to acknowledge reading and understanding the above statement

Date

Dispensing Pharmacy Information (Not applicable if vaccine was not purchased at a pharmacy)

Name of Pharmacy			**This claim is for:** (Please check all that apply) ❑ The vaccine ❑ The administration (injection) of vaccine ❑ Both the vaccine and the administration
Street Address			
City	State	Zip	
Telephone (include area code)			
NCPD Provider ID #			
National Provider ID #			

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

Name of Physician			**This claim is for:** (Please check all that apply) ❑ The vaccine ❑ The administration (injection) of vaccine ❑ Both the vaccine and the administration
Street Address			
City	State	Zip	
Telephone (include area code)			
National Provider ID #			

Vaccine Rx Information

(Remember to enclose original receipts. Original receipts must contain required information. Keep copies for your records.)

Vaccine Prescription Information:

(Complete if vaccine was obtained or administered in a pharmacy or physician's office.)

Required Information:

- Please obtain information from your physician or pharmacy if it is not provided as part of your receipt or bill.
- You must enclose the receipt(s) for the vaccine and/or administration with this form.
- Complete one line for each vaccine. Be sure the charges for the vaccine(s) and the administration(s) are separated in the table below so we can reimburse you properly.

	RX # - if received at pharmacy	Drug Name	11 Digit NDC #	Quantity	Date Filled	Date Administered	Vaccine Charge	Admin. Fee
☐	Example	Zostavax						
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If you have any questions, please contact the Customer Service Center at 800-546-5677

Mail or fax completed form to:

National Pharmaceutical Services
PO Box 407
Boys Town, NE 68010
Fax: 1-866-632-7946