



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.

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.

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: <input type="checkbox"/> Male <input type="checkbox"/> Female		
Telephone (include area code)		

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) <input type="checkbox"/> The vaccine <input type="checkbox"/> The administration (injection) of vaccine <input type="checkbox"/> 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) <input type="checkbox"/> The vaccine <input type="checkbox"/> The administration (injection) of vaccine <input type="checkbox"/> 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
<input type="checkbox"/> Example	Zostavax						
<input type="checkbox"/>							
<input type="checkbox"/>							
<input type="checkbox"/>							
<input type="checkbox"/>							
<input type="checkbox"/>							
<input type="checkbox"/>							
<input type="checkbox"/>							

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