

Medicare Part D Vaccine and Administration (Injection) Claim Form

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

Please read carefully before completing this form.

Note: There are **FOUR** parts of the form to complete. Please complete fully to ensure proper reimbursement of the claim. The form is two pages.

1. Please complete all information. An incomplete form may delay your reimbursement.
2. Please make sure the charges for the vaccine are listed separately, otherwise we cannot properly reimburse you.
3. After completing this form, the plan member should read the acknowledgment carefully, then sign and date this form (Part-2).
4. Some vaccines are covered under Part B (example: flu, PNEUMOVAX). Only vaccine claims covered under Part D should be submitted on this form.

**COMPLETED FORMS CAN BE FAXED TO:
 EnvisionRxOptions at 330-888-6015**

PART 1 – PATIENT INFORMATION		
Patient Name:		
VPCC ID #:	Patient Telephone #:	
Date of Birth:	Gender: ☐ Male ☐ Female	
Patient Address:		
City:	State:	Zip Code:
PART 2 – PATIENT ATTESTATION		
Fraud Prevention Regulation: I certify that I have received the medicine described herein and that I am the plan participant 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 VPCC; the prescription benefit manager; the insurance underwriter; sponsor; and/or policyholder. I certify that all the information entered on this form is correct. By signing this form, I certify that I have no intent to defraud the insurer and this claim does not contain or conceal any false or misleading information. I understand that false or misleading statements may be subject to criminal and/or civil penalty.		
X	Date:	
Patient signature required acknowledging understanding of the statement above.		
PART 3 – PROVIDER INFORMATION		
Provider Name:		
NPI #:	Telephone #:	
Provider Address:		
City:	State:	Zip Code:

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PART 4 – VACCINE INFORMATION (Please submit one form per vaccine)

Please complete the entire section below for the vaccine you have administered. Please fill in the vaccine name, NDC number, quantity, and vaccine charge in the space provided below. Please note reimbursement is subject to provided NDC. Please make sure to provide the correct NDC for the vaccine administered.

This claim is for a Vaccine product only. Please submit a medical claim for Vaccine administration.

Vaccine Name													
Valid 11 digit NDC						-					-		
Quantity													
Date of Administration													
Vaccine Cost													