selecthealth

Phone **855-442-9900** (toll-free)
selecthealthmedicare.org

VACCINE AND ADMINISTRATION (INJECTION) CLAIM REIMBURSEMENT FORM

This form is for reimbursement of covered Part D vaccines and their administration (injection). Please consult our Drug List at **selecthealth.org/medicare** or your Evidence of Coverage for specific coverage information. Some vaccines are covered under Part B (example: flu, PNEUMOVAX, COVID-19). Only vaccine claims covered under Part D should be submitted on this form.

1. Please complete all information. Your pharmacist or doctor's office should be able to provide some of the necessary information if it was not already provided as part of your claim or bill.
2. Enclose the receipt(s) for your vaccine and administration with this form.
3. Please, read the acknowledgement carefully, then sign and date this form.
4. Return the completed form and receipt(s) by email, fax, or mail:
   - > Email: **SHAWDPharmacy@selecthealth.org**
   - > Fax: **801-650-3170**
   - > Mail: **Attn: Pharmacy Services**
     SelectHealth
     P.O. Box 30196
     Salt Lake City, UT 84130-0196

MEMBER INFORMATION

Member Name _____ Member ID# _____

Street Address _____ City _____ State _____

ZIP _____ Ph# (_____)_____ Email Address_____

Date of Birth _____/_____/_____

CLAIM INFORMATION AND COVERAGE

This claim is for:

- ☐ The vaccine
- ☐ Administration (injection) of the vaccine
- ☐ Both the vaccine and the administration (injection) of the vaccine

You may submit a claim for Part D-covered medication dispensed by an out-of-network pharmacy only for the reasons listed below. Please check the box that applies to your situation:

- ☐ I received a vaccine at my doctor's office. (Be sure to include the receipt from the physician and complete vaccine Rx information section on the back of this form.)
- ☐ I traveled outside my plan's service area and ran out of (or lost) my medication or became ill and could not access a network pharmacy.
- ☐ I was unable to obtain my medication in a timely manner within my service area.
- ☐ My medication is not stocked regularly at an accessible network pharmacy.
- ☐ My medication was dispensed from an emergency department, provider-based clinic, outpatient surgery facility, or other outpatient setting.
- ☐ I was evacuated or displaced from my residence due to a State, federal, or other public disaster declaration.

WHERE YOU RECEIVED THE VACCINE(S)

Complete this section if you received the vaccincation(s) at a pharmacy.

Name of Pharmacy _____

Street Address _____ City _____ State _____

ZIP _____ Ph# (_____)_____

NCPDP or National Provider ID# _____

Complete this section if you received the vaccination(s) at a provider's office.

Name of Provider _____ National Provider ID# _____

Ph# (_____)_____

VACCINE RX INFORMATION

Please complete one line for each vaccine. Be sure the charges for the vaccine(s) and administration(s) are separated in the table below so we may reimburse you properly. (Remember to enclose original receipts that contain required information. Keep copies for your records.)

Rx # _____

	Brand Name	Valid 11-digit NDC	Quantity	Days Supply	Date Filed	Vaccine Charge	Vaccine Admin Fee
☐							
☐							
☐							
☐							
☐							
☐							

SIGNATURE

I certify that the medication(s) described on this form was/were received for use by the patient listed above, and that I (or the patient, if not myself) am eligible for prescription drug benefits. I also certify that the medication received was not for an on-the-job injury or covered under another benefit plan. I recognize that reimbursement will be paid directly to me, and that assignment of these benefits to a pharmacy or other party is void.

Signature _____ **Date** _____/_____/_____

Member or Representative

Questions? Call Member Services toll-free at **855-442-9900** during the following dates and times:

October 1 to March 31: Weekdays 7:00 a.m. to 8:00 p.m., Saturday and Sunday 8:00 a.m. to 8:00 p.m.

April 1 to September 30: Weekdays 7:00 a.m. to 8:00 p.m., Saturday 9:00 a.m. to 3:00 p.m., closed Sunday

Outside of these hours of operation, please leave a message and your call will be returned within one business day. TTY users, please call 711.

SelectHealth is an HMO, PPO, SNP plan sponsor with a Medicare contract. Enrollment in SelectHealth Medicare depends on contract renewal.

SelectHealth obeys federal civil rights laws. We do not treat you differently because of your race, color, ethnic background or where you come from, age, disability, sex, religion, creed, language, social class, sexual orientation, gender identity or expression, and/or veteran status. This information is available for free in other languages and alternate formats.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.

注意：如果您使用繁體中文，您可 以免費獲得語言援助服務。請致電 SelectHealth Medicare: **855-442-9900** (TTY: 711)