Vaccine Claim Form - Medicare Part D

Instructions for using this form:

1. Complete and submit this form for vaccines that are covered under Medicare Part D that were administered in your physician's office or purchased at a non-participating pharmacy. For consideration of payment, you *must* send all of the requested information for each claim to the address below. If the information is complete your claim(s) will be processed within 14 days. You will be contacted should you submit incomplete information and we are unable to obtain the information from your pharmacy or physician.

2. Please complete section A and B of the Vaccine Claim form and submit the following for review of coverage:
   - An itemized receipt or statement including the following information:
     - Physician Name and Address
     - Patient Name
     - Date of Service
     - Name of vaccine, NDC number and/or procedure code for vaccine
     - Itemized charge for the vaccine and administration fee
   - Proof of payment:
     - Documented in itemized statement or
     - Submit the front and back of the cashed check or copy of credit card receipt

   Please make copies for your records.

3. Mail completed form to**: Blue Cross Blue Shield of Massachusetts, Medicare Advantage, Appeals Coordinator, P.O. Box 55007, Boston, MA 02205**

This document is available in other formats. For more information, call 1-800-200-4255, 8:00 a.m. to 8:00 p.m. Eastern Time, seven days a week, January 1 through February 14 and October 1 through December 31. From February 15 through September 30, you can call us 8:00 a.m. to 8:00 p.m. Eastern Time, Monday through Friday. TTY users call 1-800-522-1254.

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All beneficiaries must use network pharmacies to access their prescription drug benefit, except under non-routine circumstances. Quantity limitations and restrictions may apply.

A. Cardholder - Information		**Today's Date:**		
Cardholder's Name (Last, First, MI)		Cardholder ID Number		
Address		City	State	Zip Code
		Cardholder's Date of Birth / /		Gender □ M □ F
Cardholder Telephone Number	Plan Name			

B. Claim information		
1. Vaccine name	Date of Service	Charge
Administration fee	Date of Service	Charge
2. Vaccine name	Date of Service	Charge
Administration fee	Date of Service	Charge
Physician Name and Address		

Cardholder Signature:______________________________________ Date:__________

Reimbursement of submitted claims is subject to your prescription benefit program and not guaranteed. Reimbursement will be according to the parameters of your prescription benefit plan. It will be only for the amount your program would have paid on your behalf. The amount of reimbursement may be significantly lower than the original amount you paid.