Employee Flu Shot Claim Form For



Section 1 – To Be Completed by Employee (*Please PRINT legibly*)

1 Subscriber ID				Medical ID card to the	he Place of Ser	vice.						
Subscriber ID Number Group Number												
-			ler)									
3. Subscriber Name (primary policy holder)												
4. Patient's Name (First / Middle Initial / Last)												
5. Patient's Date of Birth//												
6. Sex M		1 / DD / YY)										
		CI	AIM INFORMAT	TION (for office use of	only)							
DX: <u>V04.81</u>												
	DIACEOF			Description of								
DATE OF SERVICE	PLACE OF SERVICE	TYPE OF SERVICE	PROCEDURE CODES	Description of Code	DX LINK	CHARGES	UNITS					
	11	1	90658	Influenza virus vaccine	1	\$	1					
	11	1	G0008	Administration of influenza virus vaccine	1	\$	1					
	11	1	90470	H1N1 immunization administration (intramuscular, intranasal)	1	\$	1					
					Total Charge \$							
			PROVIDER	R INFORMATION:								
Name,			110 / 12 11	<u></u>								
Address.												
			, Zip Code,									
				ID NUMBER,								
Administrator n	iame,		Aam	iinistrator Signature,								