Employee Flu Shot Claim Form
For

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

Please bring this form and your Medical ID card to the Place of Service.

1. Subscriber ID Number _____

2. Group Number_____

3. Subscriber Name (primary policy holder) _____
(First / Middle Initial / Last)

4. Patient's Name _____
(First / Middle Initial / Last)

5. Patient's Date of Birth ___/___/_____
(MM / DD / YY)

6. Sex __ M __ F

CLAIM INFORMATION (for office use only)

DX: V04.81

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 INFORMATION:

Name,_____

Address,_____

City_____, State_____, Zip Code,_____

Phone Number,_____ FEDERAL TAX ID NUMBER,_____

Administrator name,_____ Administrator Signature,_____

Send completed form to: United Health Care Center PO Box 30555
Salt Lake City, UT 84130-0555 or FAX to 801-233-9580