Flu Shot Reimbursement Form

Fill out this form if you paid for a flu shot for yourself or for others on your plan. Complete one form per individual.
Y MUST eceipt.

Plan subscriber information:

Name: .....

Address: .....

City: ..... State: ..... ZIP: .....

Fill in the information below for each person who received a flu shot, including yourself. Attach additional forms if needed.

Member ID# .....

Name: .....

Date of birth: .....

Cost of flu shot: .....

Date received: .....

Facility or pharmacy where received: .....

Member signature: .....

I have paid for my flu shot(s) out-of-pocket, and I am requesting reimbursement for that cost.