



**FLU SHOT
REIMBURSEMENT FORM**

If you paid for your flu shot from an out of network provider, please fill out this form.

Mercy MedicareADVANTAGE	
Name:	Member ID#: M _____
Date Received:	Fee Paid for Flu Shot: \$
Location:	
_____ (Vendor name, retail/grocery store, health department, etc.)	

TO RECEIVE YOUR REIMBURSEMENT

To receive your reimbursement in a timely manner please submit this form and your receipt within 90 days.

- Attach your paid receipt to this form.
- Complete all information on the form.**
- Return the **completed** form to Mercy MedicareADVANTAGE, P.O. Box 4568, Springfield, MO 65808.

* For Claims Use only: Influenza DX: V04.8; CPT code: 90658; Administration Fee: 90465-90474

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