



**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 codes: 90666, 90667, 90668;
Fluzone® High Dose: 90662; Administration fee: 90465-90474