Flu Shot Reimbursement Form

UPMC HEALTH PLAN

Please submit this form ONLY if flu shot was paid for by member(s) and/or subscriber.

Subscriber: Please complete this section for the subscriber, whether or not he or she received a flu shot.

Name: ______________________________

Address: ______________________________

City: ______________ State: ______________ Zip Code: __________

Member: Complete this section in its entirety for each person who received a flu shot under the above subscriber's coverage, including the subscriber. If more than two members received a flu shot, you can photocopy this form, download additional reimbursement forms at www.upmchealthplan.com, or obtain additional copies by calling the number that is on the back of your member ID card.

Member 1

Member ID# ______________________________

Name ______________________________

Date of Birth ______________________________

Cost of Flu Shot ______________________________

Date Received ______________________________

Facility Where Received ______________________________

Member 2

Member ID# ______________________________

Name ______________________________

Date of Birth ______________________________

Cost of Flu Shot ______________________________

Date Received ______________________________

Facility Where Received ______________________________

Subscriber Signature (Required) ______________________________

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

For your reimbursement, please mail this form and a copy of your flu shot receipt(s) to:

Attention: Special Processing
UPMC Health Plan
P.O. Box 2966
Pittsburgh, PA 15230

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