MASSACHUSETTS

Vaccine Claim Form - Medicare Part D

Instructions for using this form:

1. Complete and submit this form for vaccines that are covered under Medicare Part D that were administered in your physician's office or purchased at a non-participating pharmacy. For consideration of payment, you *must* send all of the requested information for each claim to the address below. If the information is complete your claim(s) will be processed within 14 days. Your reimbursement request may be denied if you submit incomplete information and we are unable to obtain the information from your pharmacy or physician.

2. Please complete section A and B of the Vaccine Claim form and submit the following for review of coverage:
   - An itemized receipt or statement including the following information:
     - Physician Name and Address
     - Patient Name
     - Date of Service
     - Name of vaccine, NDC number and/or procedure code for vaccine
     - Itemized charge for the vaccine and administration fee

   Please make copies for your records.

3. Mail, email or fax completed form to:

   Mail: **Blue Cross Blue Shield of Massachusetts, Medicare Advantage, Appeals Coordinator, P.O. Box 55007, Boston, MA 02205**

   Email: **MedicareAdvantageRXAppeals@bcbsma.com**

   Fax: **1-617-246-8506**

This document is available in other formats. For more information, call 1-800-200-4255, 8:00 a.m. to 8:00 p.m. Eastern Time, seven days a week except April 1 through September 30 when we are open Monday through Friday. TTY users call 711.

Blue Cross and Blue Shield of Massachusetts is an HMO and PPO plan with a Medicare contract. Enrollment in Blue Cross Blue Shield of Massachusetts depends on contract renewal. Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association

All beneficiaries must use network pharmacies to access their prescription drug benefit, except under non routine circumstances. Quantity limitations and restrictions may apply.
Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation or gender identity.
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-200-4255 (TTY: 711).
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-200-4255 (TTY: 711).

A. Cardholder – Information			**Today's Date:**		
Cardholder's Name (Last, First, MI)			Cardholder ID Number		
Address:			City	State	Zip Code
			Cardholder's Date of Birth / /		Gender ☐M ☐ F
Cardholder Telephone Number:		Plan Name:			

B. Claim information		
1. Vaccine name:	Date of Service:	Charge:
Administration fee:	Date of Service:	Charge:
NDC#	Quantity:	
2 .Vaccine name:	Date of Service:	Charge:
Administration fee:	Date of Service:	Charge:
NDC#	Quantity:	
Physician Name and Address:	Physician NPI#	

Cardholder Signature:_____

Date:_____

Reimbursement of submitted claims is subject to your prescription benefit program and not guaranteed. Your request will be processed per the plan's allowed amount and reimbursement will be according to the parameters of your prescription benefit plan. The amount of reimbursement may be significantly lower than the original amount you paid.