Vaccine Claim Form Information

Vaccine 1

VACCINE NAME:

Date Filled (MM/DD/YY) ☐☐☐☐☐☐☐☐	Prescribing Physician Name: _____
Total Paid for Vaccine ($ Amount) ☐☐☐☐☐☐☐☐	Prescribing Physician Address: _____
Total Paid for Administration Fee ($ Amount) ☐☐☐☐☐☐☐☐	Prescribing Physician NPI Number ☐☐☐☐☐☐☐☐☐☐
Vaccine National Drug Code (NDC) Number ☐☐☐☐☐☐☐☐☐☐☐	1. Administered Location: ☐ Physician Office ☐ Clinic ☐ Pharmacy 2. Is this a 2-part vaccine (i.e., Shingrix): a. ☐ Yes b. ☐ No 3. Was the shot received the: ☐ First part in a series ☐ Second part in a series
Prescription Number (If Filled at a Pharmacy ONLY) ☐☐☐☐☐☐☐☐☐☐☐☐	

Vaccine 2

VACCINE NAME:

Date Filled (MM/DD/YY) ☐☐☐☐☐☐☐☐	Prescribing Physician Name: _____
Total Paid for Vaccine ($ Amount) ☐☐☐☐☐☐☐☐	Prescribing Physician Address: _____
Total Paid for Administration Fee ($ Amount) ☐☐☐☐☐☐☐☐	Prescribing Physician NPI Number ☐☐☐☐☐☐☐☐☐☐
Vaccine National Drug Code (NDC) Number ☐☐☐☐☐☐☐☐☐☐☐	1. Administered Location: ☐ Physician Office ☐ Clinic ☐ Pharmacy 2. Is this a 2-part vaccine (i.e., Shingrix): a. ☐ Yes b. ☐ No 3. Was the shot received the: ☐ First part in a series ☐ Second part in a series
Prescription Number (If Filled at a Pharmacy ONLY) ☐☐☐☐☐☐☐☐☐☐☐☐	

Comments

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