BROWN & TOLAND PHYSICIANS

Shingrix Vaccination Reimbursement Form 2020-2021

Brown & Toland Physicians reimburses **Commercial HMO members** up to **$185** per dose, for Shingrix vaccine (recombinant zoster vaccine) obtained from a pharmacy, public health department, flu clinic or other location outside a Brown & Toland physician office. *The Shingrix vaccine requires that you receive pre-authorization to receive this service. If you are on a Medicare Advantage Plan do not seek reimbursement for the vaccination Medicare Part D should be billed.*

To receive reimbursement, please complete the following steps:

Step 1: Complete all information on the Reimbursement Form (one form per member) as follows:

Part 1

- **Fill in your name (first name then last name)**
- **Date of Birth**
- **Phone number where you can be reached if additional information is needed**
- **Your address**
- **Your Health Plan name**
- **Your subscriber id to your health plan**
- **The name of your Physician**
- **The name of the business where you received the vaccination**
- **Indicate if this is the 1st or 2nd Shingrix dose.**

Part 2

- **Take the form with you and present it at the counter at the pharmacy as they need to fill in information that is critical to receive the reimbursement for the vaccination.**
- **Ensure the form is returned to you by the pharmacy and completed in entirety.**
- **Secure and retain the cash register receipt. Copy the receipt and attach the copy to the form.**

Step 2: Mail the reimbursement form and copy of the cash register receipt within 60 days to:

Brown & Toland Physicians
Attn: Claims/Adjustment Unit
P.O. Box 72710
Oakland, CA 94612-8910

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Shingrix Vaccine
Reimbursement Form

Part 1 Completed by the Patient/Member ***(Please Print)***

First Name: ______________________ **Last Name:** ______________________

Date of Birth: ____________________ **Phone Number:** __________________

Address: ____

Please refer to your Health Plan or Insurance ID card for this information

Health Plan: ______________________ **Subscriber ID:** ___________________

Your Doctor's Name: ____

□ **Shingrix (shingles) Dose 1** □ **Shingrix (shingles) Dose 2**

Where did you receive the vaccination? __________________________________

Part 2: Completed by the Pharmacy ***(Please Print) This information is required for reimbursement***

Date: _____________________ ***NDC#:*** ________________________

Affix the prescription receipt (usually placed on the prescription bag) above the line below:

Prescription Receipt: ____

Give this Form back to the Patient/Member

Patient/Member - Attach a copy of the Cash Register Receipt to this Form (must be completed in entirety) and mail within 60 days of the date of the cash register receipt to:

Brown & Toland Physicians
Attn: Claims/Adjustment Unit
P.O. Box 72710
Oakland, CA 94612-8910