Medicare Part D Vaccine and Administration (Injection) Claim Form

This claim form is for provider reimbursement of covered Part D vaccines and their administration (injection). Please consult the Formulary for specific coverage information.

Please read carefully before completing this form.

Note: There are **FOUR** parts of the form to complete. Please complete fully to ensure proper reimbursement of the claim. The form is two pages.

1. Please complete all information. An incomplete form may delay your reimbursement.
2. Please make sure the charges for the vaccine are listed separately, otherwise we cannot properly reimburse you.
3. After completing this form, the plan member should read the acknowledgment carefully, then sign and date this form (Part-2).
4. Some vaccines are covered under Part B (example: flu, PNEUMOVAX). Only vaccine claims covered under Part D should be submitted on this form.

COMPLETED FORMS CAN BE FAXED TO: EnvisionRxOptions at 1-877-503-7231.

PART 1 – PATIENT INFORMATION		
Patient Name:		
Virginia Premier ID #:	Patient Telephone #:	
Date of Birth:	Gender: □ Male □ Female	
Patient Address:		
City:	State:	Zip Code:

PART 2 – PATIENT ATTESTATION		
Fraud Prevention Regulation: I certify that I have received the medicine described herein and that I am the plan participant named and am eligible for prescription benefits. I also certify that the medicine received is not for treatment of an on-the-job injury or covered under another benefit plan. I authorize release of all information pertaining to this claim to Virginia Premier Advantage Elite (HMO SNP) / Virginia Premier Advantage Gold (HMO) / Virginia Premier Advantage Platinum (HMO) (Virginia Premier); the prescription benefit manager; the insurance underwriter; sponsor; and/or policyholder. I certify that all the information entered on this form is correct. By signing this form, I certify that I have no intent to defraud the insurer and this claim does not contain or conceal any false or misleading information. I understand that false or misleading statements may be subject to criminal and/or civil penalty.		
X	Date:	
Patient signature required acknowledging understanding of the statement above.		

PART 3 – PROVIDER INFORMATION		
Provider Name:		
NPI #:	Telephone #:	
Provider Address:		
City:	State:	Zip Code:

PART 4 – VACCINE INFORMATION (Please submit one form per vaccine)

Please complete the entire section below for the vaccine you have administered. Please fill in the vaccine name, NDC number, quantity, and vaccine charge in the space provided below. Please note reimbursement is subject to provided NDC. Please make sure to provide the correct NDC for the vaccine administered.

This claim is for a Vaccine product only. Please submit a medical claim for Vaccine administration.

Vaccine Name													
Valid 11 digit NDC						-					-		
Quantity													
Date of Administration													
Vaccine Cost													

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Notice of Non-Discrimination

Virginia Premier Health Plan, Inc. (Virginia Premier) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Virginia Premier does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Virginia Premier:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Natasha Byrd, Grievances & Appeals Manager.

If you believe that Virginia Premier has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Natasha Byrd, Grievances & Appeals Manager
P.O. Box 5244
Richmond, VA 23220
1-877-739-1370, TTY: 711
Fax: 804-649-9647
grievancesandappeals@vapremier.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Natasha Byrd, Grievances & Appeals Manager is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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Multi-Language Insert
Multi-Language Interpreter Services

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-877-739-1370 (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-739-1370 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-739-1370 (TTY: 711) 번으로 전화해주십시오.

CHÚ Ý: Nếu bạn nói Tiếng Việt, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Xin gọi số 1-877-739-1370 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-739-1370 (TTY: 711)。

ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-739-1370 (الهاتف النصي :TTY 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, may mga magagamit kang libreng serbisyo ng tulong sa wika. Tumawag sa 1-877-739-1370 (TTY: 711).

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با شماره 1-877-739-1370 (TTY: 711) تماس بگیرید.

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-877-739-1370 (መስማት ለተሳናቸው: 711).

توجہ دیں: اگر آپ اردو بولتے ہیں تو، زبان سے متعلق اعانت کی خدمات، آپ کے لیے مفت دستیاب ہے۔ 1-877-739-1370 (TTY: 711) پر کال کریں۔

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-739-1370 (ATS: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-739-1370 (линия TTY: 711).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-739-1370 (TTY: 711) पर कॉल करें।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-739-1370 (TTY: 711).

মনোযোগ দিনঃ আপনি যদি বাংলাতে কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন 1-877-739-1370 (TTY: 711)।

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YI LE: I balè u pot tila hop won ngim bod i kobol mahop i la hola wè ni hop won, u saa béé to yom. Sébél 1-877-739-1370 (TTY: 711).

GENU NTI: Ọ buru na ina asu asusu Igbo, enyemaka na-ahazi asusu, bu n’efu, diri gi mgbe niile. Kpoo nomba ndi a 1-877-739-1370 (TTY: 711).

AKIYESI: Bi o ba nsọ èdè Yorùbá, ọfé ni iranlọwọ lori èdè wa fun yin. Ẹ pe ẹrọ-ibanisọrọ yi 1-877-739-1370 (TTY: 711).

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