

# Influenza Vaccine Reimbursement Form

Please use this form to obtain reimbursement if you received a flu shot or FluMist in a non-participating location. Please submit one form for each member.

*Please print*

Member identification number \_\_\_\_\_

*Member information*

Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ Date of birth \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP code \_\_\_\_\_

Amount paid for flu shot or FluMist \_\_\_\_\_

Location where you received the flu shot or FluMist \_\_\_\_\_

Date you received the flu shot or FluMist \_\_\_\_\_

AmeriHealth members with HMO, POS, and PPO health plans can receive up to a \$25 reimbursement by mailing this form and paid receipt to the address below.

AmeriHealth Processing Center  
P.O. Box 41574  
Philadelphia, PA 19101-1574



**AmeriHealth**<sup>®</sup>