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®