

# Flu Vaccine

**IMPORTANT: This form must be legible and completed entirely to be accepted.**

Forms that are not completed or legible will be returned and payment will be delayed. Roster must be submitted within 180 days of service for reimbursement.

Employer Name: \_\_\_\_\_

Name of Clinic/Facility providing shots: \_\_\_\_\_ Name of Physician/PA: \_\_\_\_\_

Physical Address of Clinic/Facility providing shots: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Maximum allowed per shot is \$26.00, or as defined by contract.**

	Date of vaccine	Sanford Health Plan Member ID	Member Last Name	Member First Name	Date of Birth	Price of Shot	NDC # 2022-23	CPT Code
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Payee (name of clinic/facility): \_\_\_\_\_ Tax ID# (REQUIRED) \_\_\_\_\_

Remittance address: \_\_\_\_\_ NPI # (REQUIRED) \_\_\_\_\_

Return form to:

**Mail:** Sanford Health Plan | Attn: Claims Department | PO Box 91110 | Sioux Falls, SD 57109-1110

**Fax:** (605) 328-6840 **Email:** HealthPlanClaimsfax@SanfordHealth.org