VACCINATION REIMBURSEMENT FORM

IMPORTANT!!

Instructions for filing your claim:
1. Complete the Vaccination Reimbursement Form in full.
2. Attach itemized bill for the FLU and/or SHINGLES VACCINATION
3. Bill/Receipt must indicate the service is PAID IN FULL.
4. Return the Vaccination Reimbursement Form and the Paid Receipt to the Fund Office.

1. Member Last Name: _____ Member First Name: _____

   Last 4 Digits of SS#: XXX-XX-_____

   Address: _____

   City, State, Zip Code: _____

   Home Phone Number: _____

2. Patient Last Name: _____ Patient First Name: _____

   Patient is: ____ Member ____ Spouse

   Patient's Date of Birth_____ Last 4 Digits of Patient's SS#: XXX-XX-_____

3. Is Patient covered by Medicare Part B? _____ Yes _____ No

   Reminder: If you are enrolled in Medicare Part B your claim for your Flu Vaccination must be submitted directly to Medicare Part B!!

4. _____

   SIGNATURE OF PATIENT **DATE**

RETURN THE VACCINATION REIMBURSEMENT FORM AND YOUR PAID RECEIPT TO THE FUND OFFICE (SEE BELOW):

Sheet Metal Workers' Local 73 Welfare Fund
Attn: Claims Department
4530 Roosevelt Road
Hillside, IL 60162