SOUTH COUNTRY
HEALTH ALLIANCE

Zostavax Vaccine and Administration (Injection) Claim Form

This claim form is an invoice for providers to submit claims directly to South Country Health Alliance for payment. Both member and provider must complete.

FOR SOUTH COUNTRY MEMBERS

INSTRUCTIONS *Read carefully before completing form*

1. **Complete all information on this side of the form. An incomplete form may delay payment to the provider.**
2. **When you have filled out this side, sign and date the form. Give the form to your doctor to complete the other side.**
3. **Leave this original form with the doctor. Ask the doctor to make a copy for you to keep.**

Member Information

G								0	1

Member ID from SCHA Card

____
Member Name (First, Last)

____
Street Address

____
City **State** **ZIP**

Date of Birth M M D D Y Y Y Y

ACKNOWLEDGEMENT

I certify that I received the vaccine described on this form, and that I am eligible for prescription drug benefits. I recognize that payment will be paid directly to the clinic and/or prescriber.

____
Member Signature & Date

South Country Health Alliance Member Services

1-866-567-7242 (toll free) • TTY 1-877-824-5611 • 8:00 a.m. - 8:00 p.m., 7 days a week

Attention. If you want free help translating this information, call the above number.

ملاحظة: إذا أردت مساعدة مجانية في ترجمة هذه المعلومات، فاتصل على الرقم الموجود أعلاه.

កំណត់សំគាល់ បើអ្នកចង់បានជំនួយបកប្រែពត៌មាននេះដោយមិនគិតថ្លៃ សូមទូរស័ព្ទ ទៅលេខនៅខាងលើ។

Pažnja. Ako vam je potrebna besplatna pomoć za prevod ove informacije, nazovite gornji broj.

Ceeb toom. Yog koj xav tau kev pab txhais cov xov no dawb, thov hu rau tus xov tooj saud.

ໂປຼດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງໂທຣຕາມເລກໂທຣທີ່ຢູ່ຂ້າງເທີງນີ້.

Hubaddhu. Yoo akka odeeffannoon kun sii hiikamu gargaarsa tolaa feeta ta'e, lakkoofsa armaa olii bilbili.

Внимание. Если вам нужна бесплатная помощь в переводе этой информации, позвоните по указанному выше телефону.

Ogow. Haddii aad dooneyso in lagaa kaalmeeyo tarjama dda macluumaadkani oo lacag la'aan ah, wac lambarka kore.

Atención. Si desea recibir asistencia gratuita para traducir esta información, llame al número que aparece más arriba.

Chú Ý. Nếu quý vị cần dịch thông tin này miễn phí, xin gọi số nêu trên.

LB5-0013 (10-09)

This information is available in other forms to people with disabilities by calling **1-866-567-7242** (toll free) or **1-877-824-5611** (TTY for the hearing impaired), or 711, or through the Minnesota Relay at 1-800-627-3529 (TTY, Voice, ASCII, Hearing Carry Over), or 1-877-627-3848 (speech to speech relay service).

South Country Health Alliance is a Medicare Advantage organization with a Medicare Contract.

H2419, H5703_1453 File & Use 07/26/2010

SOUTH COUNTRY HEALTH ALLIANCE

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FOR SOUTH COUNTRY PROVIDERS

PROVIDER INSTRUCTIONS *Read carefully before completing form*

1. **Complete all information on this side of the form. An incomplete form may delay your payment.**
2. **Do not bill the member.**
3. **Make sure all charges for the vaccine and administration (injection) are listed separately, otherwise we cannot properly pay you.**
4. **The member must fill out *and* sign and date the other side of the form.**
5. **Paper Zostavax Claims should be submitted to: SCHA Member Services, 110 West Fremont Street, Owatonna, MN 55060, or faxed to 1-507-431-6328.**

Medical Clinic Information

Clinic Name

Street Address

City **State** **ZIP**

Telephone ___-___-____

National Provider ID Number ______________

Prescribing Physician Information

Physician Name

Street Address

City **State** **ZIP**

Telephone ___-___-____

National Provider ID Number ______________

Provider Signature & Date

Provider Vaccine Rx Information

(Required information. Please submit one form per vaccine.)
Please check the appropriate box for the vaccine received.

						90736	90471
	Brand Name	Valid NDC#	Quantity	Days Supply	Date Administered	Vaccine Charge	Vaccine Admin. Fee
☐	Zostavax	00006496300	1	1			
☐	Zostavax	00006496341	1	1			
☐	Zostavax	54868570300	1	1			

Any person who knowingly and with intent to defraud, injure or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent insurance act which is a crime and may be subject to criminal or civil penalties including fines and/or imprisonment, or denial of benefits.