Flu Vaccine Claim Form

130 DeSiard Street,
Suite 300
Monroe, LA 71201
(318) 361-0900
(318) 361-2159 Fax

Instructions: Please complete a separate claim form for each patient. Allow up to 30 days from the date you submit the completed claim form for a response from Vantage. Keep a copy of all documents you submit for your records. Please mail or fax the completed claim form and a copy of all receipts with this form to Vantage. For Medicare members, claims must be submitted within 180 days of the date of service. For all other members, claims must be submitted within 90 days of the date of service. Claims not submitted within the required timeframes are not eligible for reimbursement. Submission of this form does not guarantee reimbursement.

PATIENT INFORMATION	INSURED INFORMATION (on ID Card)
Patient Name	**Insured ID Number & Dep. Code**
Patient Address	**Insured Name**
City, State, Zip	**Insured Address**
Patient DOB	**City, State, Zip**
Employer's Name	**Telephone#**
Pharmacy Name	**Insurance Plan Name**
Diagnosis Code	

INSURED MEMBER AUTHORIZATION

I understand that any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false, incomplete or misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime punishable by fine and imprisonment under Federal and State laws.

Signature of Insured Member: _____ Date: _____

OFFICE USE ONLY

Date of Service	Procedure Code	Charges
	TOTAL	

Notes: