Flu Shot Reimbursement Form

Fill out this form if you paid for a flu shot for yourself or for others on your plan. Complete one form per individual. You **MUST** include a receipt.

Plan member information:

Name: .....

Address: .....

City: ..... State: ..... ZIP: .....

Fill in the information below for each person who received a flu shot, including yourself. Attach additional forms if needed.

Member ID# .....

Name: .....

Date of birth: .....

Cost of flu shot: .....

Date received: .....

Facility or pharmacy where received: .....

Member signature: .....

I have paid for my flu shot(s) out-of-pocket, and I am requesting reimbursement for that cost.

Mail this form and a copy of your flu shot receipt(s) to:

Attention: Special Processing
UPMC Health Plan
PO Box 2966
Pittsburgh, PA 15230

Phone: **1-844-201-4674** Fax: **1-844-201-4655** TTY: **711**

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UPMC HEALTH PLAN