

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 subscriber 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

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