

Flu Shot Reimbursement Form

Subscriber Information

Complete this section for the subscriber, whether or not he or she received a flu shot.

Name: _____

Address: _____

City: _____

State: _____

Zip Code: _____

Member Information

Complete this section for each person who received a flu shot under the above subscriber's coverage, including the subscriber. If more than two members received a flu shot, you can photocopy this form, download additional reimbursement forms at www.upmchealthplan.com, or obtain additional copies by calling the number that is on the back of your member ID card.

Member 1

Member ID# _____

Name _____

Date of Birth _____

Flu Shot Location _____

Date Received _____

Member 2

Member ID# _____

Name _____

Date of Birth _____

Flu Shot Location _____

Date Received _____

Subscriber Signature

Required for processing

For your reimbursement, please mail this form and your flu shot receipt(s) to:

Attention: Special Processing
UPMC Health Plan
P.O. Box 2966
Pittsburgh, PA 15230