Physicians Health Choice | For Health. For Wellness. For Life.

MEMBER REIMBURSEMENT FORM (PART D VACCINES)

MEMBER INFORMATION (TO BE COMPLETED BY THE MEMBER)

PLAN NAME: **PHYSICIANS HEALTH CHOICE**	MEMBER ID #			
MEMBER NAME (Last Name, First Name, M.I.)	MEMBER SEX ☐ MALE ☐ FEMALE	DATE OF BIRTH		
		MO	DAY	YEAR
MAILING ADDRESS OF MEMBER (Number and Street)	CITY	ZIP CODE		

I CERTIFY THAT THE MEMBER FOR WHOM THIS CLAIM IS MADE IS A COVERED PERSON IN THIS BENEFIT PROGRAM AND THAT THE VACCINE(S) WERE ADMINISTERED TO THE NAMED MEMBER. I ALSO CERTIFY THAT THE CLAIM(S) BEING SUBMITTED FOR PAYMENT ARE NOT ELIGIBLE FOR PAYMENT ARE NOT ELIGIBLE FOR PAYMENT UNDER A NO-FAULT AUTOMOBILE OR WORKERS COMPENSATION PROGRAM.

MEMBER/Authorized Representative Signature: **X**____

Telephone Number: (   )

VACCINE INFORMATION (TO BE COMPLETED BY THE DOCTOR)

DATE ADMINISTERED	VACCINE NAME & STRENGTH	
NATIONAL DRUG CODE (NDC #) ▬ ▬ ▬ ▬ ▬ / ▬ ▬ ▬ ▬ / ▬ ▬	METRIC QTY. ADMINISTERED	AMOUNT PAID BY MEMBER FOR VACCINE INGREDIENT COST $
ADDITIONAL INFORMATION		AMOUNT PAID BY MEMBER FOR VACCINE ADMINISTRATION $

PROVIDER INFORMATION

NAME, ADDRESS & TELEPHONE NUMBER OF PROVIDER	PROVIDER NPI#

I CERTIFY THAT THE CHARGES SHOWN ARE FOR THE VACCINES ADMINISTERED TO THIS RECIPIENT. (Signature of the Provider is required)

X____

PLEASE READ INSTRUCTIONS ON REVERSE SIDE

INSTRUCTIONS

A. WHEN TO USE THIS FORM

This claim form is to be used **only** for reimbursement of payment made to your doctor upon the administration of a covered vaccine.

Bring this claim form to your doctor when you need a vaccine

Submit this form to the address below to receive prompt payment.

B. HOW TO COMPLETE THIS FORM

1. Complete the upper portion of the claim form under **Member Information.** Transfer the Member ID # and Plan Name from your identification card.

2. Have your Doctor complete the **VACCINE INFORMATION** section for each vaccine administered.

   IMPORTANT: The quantity, vaccine name and strength **and** eleven digit National Drug Code (NDC) is required and **must** appear on your submitted claim(s) or receipt(s).

3. An original **paid** receipt from your doctor must accompany this form.

4. **Your Doctor MUST sign this form in the appropriate section**

5. Claim forms submitted without the required information will cause payment delays or may be returned.

C. WHERE TO MAIL THIS FORM

1. Mail this form and your original paid pharmacy receipt(s) to:
   Envision Rx Options, Inc.
   2181 East Aurora Road, Suite 201
   Twinsburg, Ohio 44087

2. Please allow up to eight weeks for processing and payment of your claims.

3. You may call 1-866-417-3071 for questions or problems concerning your submitted claims.

CLAIMS WITH MISSING OR ILLEGIBLE INFORMATION WILL BE RETURNED!