



**Instructions** Read carefully before completing this form.

1. Please complete all information. An incomplete form may delay your reimbursement.
2. Please make sure the charges for the vaccine and the administration (injection) are listed separately, otherwise we cannot properly reimburse you.
3. Your pharmacist or doctor's office should be able to provide some of the necessary information if it was not already provided as part of your claim or bill.
4. You should enclose the receipt(s) for your vaccine with this form.
5. After completing this form, the plan member should read the acknowledgment carefully, then sign and date this form.
6. Return the completed form and receipt(s) to: **WPS Health Insurance PDP, c/o Medco Health Solutions, Inc., P.O. Box 14718, Lexington, KY 40512.**
7. Some vaccines are covered under Part B (example: flu, Pneumovax). Only vaccine claims covered under Part D should be submitted on this form.

**Vaccine Rx Information** (Required Information. Please submit one form per vaccine.)

Please check the appropriate box for the vaccine you have received. If the vaccine you received does not appear below, please fill in the vaccine name, NDC number, quantity, vaccine charge, and administration fee in the blank space provided below.

				Rx#			
	Brand Name	Valid 11-digit NDC#	Quantity	Days Supply	Date Filled	Vaccine Charge	Vaccine Admin. Fee
<input type="checkbox"/>	ZOSTAVAX*	00006496300	1 Vial	1			
<input type="checkbox"/>	ZOSTAVAX*	00006496341	1 Vial	1			
<input type="checkbox"/>	ZOSTAVAX*	54868570300	1 Vial	1			
<input type="checkbox"/>	DECAVAC	49281029183	0.5 mL	1			
<input type="checkbox"/>	TETANUS TOXOID	49281082010	0.5 mL	1			
<input type="checkbox"/>	ENGERIX-B	58160082111	1 mL	1			
<input type="checkbox"/>	ENGERIX-B	58160082146	1 mL	1			
<input type="checkbox"/>	M-M-R II VACCINE	00006468100	1 mL	1			
<input type="checkbox"/>	TWINRIX	58160081546	1 mL	1			
<input type="checkbox"/>	HAVRIX	58160082611	1 mL	1			
<input type="checkbox"/>	HAVRIX	58160082646	1 mL	1			
<input type="checkbox"/>	RECOMBIVAX HB	00006499500	1 mL	1			
<input type="checkbox"/>	VAQTA	00006484100	1 mL	1			
<input type="checkbox"/>	VARIVAX VACCINE	00006482700	1 Vial	1			
<input type="checkbox"/>	GARDASIL†	00006404500	0.5 mL	1			
<input type="checkbox"/>							

\*Zostavax is only covered for members aged 50 and over.

†Gardasil is only covered for members between the ages of 9 and 26.

