



**Independence
Blue Cross**

Influenza Vaccine Reimbursement Form

Please use this form to obtain reimbursement if you received a flu shot or FluMist in a location other than a doctor's office. Please submit one form for each member.

Please print

Member identification number _____

Member information

Last _____ First _____ M.I. _____ Date of birth _____

Address _____

City _____ State _____ ZIP code _____

Type of service: Flu shot FluMist **Amount paid** _____

Location where you received the flu shot or FluMist _____

Date you received the flu shot or FluMist _____

Claims Department (internal use)

Procedure Code #	Description
90654	Influenza virus, split virus, preservative free, for intradermal use
90657	Influenza virus vaccine, split virus, for children 6 – 35 months of age, for intramuscular use
90658	Influenza virus vaccine, for use in individuals 3 years of age and above, for intramuscular use
90660	Influenza virus vaccine, live, for intranasal use
Diagnosis Code #	Description
V04.81	Prophylactic vaccination and inoculation influenza

Mail this form and receipt for reimbursement up to \$25 to:

**Keystone Health Plan East
Keystone 65 HMO**
P.O. Box 69353
Harrisburg, PA 17106-9353

**BlueCard PPO
Personal Choice®
Personal Choice 65SM PPO**
P.O. Box 69352
Harrisburg, PA 17106-9352