SOUTH COUNTRY MEMBER FILL OUT THIS SIDE

Medicare Part D Vaccine and Administration (Injection) Claim Form

This claim form is an invoice for providers to submit claims directly to South Country Health Alliance for payment. Both member and provider must complete.

PLEASE NOTE: This claim form is *only* for the use of members with Medicare Part D benefit coverage through South Country.

PATIENT/MEMBER INSTRUCTIONS *Read carefully before completing form*

1. Complete all information in this section of the form. An incomplete form may delay payment to the provider.
2. When you have filled out this section, sign and date the form. Give the form to your doctor to complete the other side (Page 2).
3. Leave this original form with the doctor. Ask the doctor to make a copy for you to keep.

Member Information

G _ _ _ _ _ _ _ _ 0 1

Member ID on South Country Card

_____

Member Name (First, Last)

_____

Street Address

_____ ____ _____

City State ZIP

Date of Birth _ _ _ _ _ _ _ _
M M D D Y Y Y Y

ACKNOWLEDGEMENT

I certify that I received the vaccine described on this form, and that I am eligible for prescription drug benefits. I recognize that payment will be paid directly to the clinic and/or prescriber.

_____

Member Signature & Date

South Country Health Alliance Member Services

1-866-567-7242 (toll free) • TTY 711 • 8:00 a.m. - 8:00 p.m., 7 days a week

HEALTH CARE PROVIDER FILL OUT THIS SIDE

Medicare Part D Vaccine and Administration (Injection) Claim Form

This claim form is an invoice for providers to submit claims directly to South Country Health Alliance for payment. Both member and provider must complete.

PLEASE NOTE: This claim form is *only* for the use of members with Medicare Part D benefit coverage through South Country.

PROVIDER INSTRUCTIONS *Read carefully before completing form*

1. Complete all information in this section of the form. An incomplete form may delay your payment.
2. Do not bill the member.
3. Make sure all charges for the vaccine and administration (injection) are listed separately, otherwise South Country cannot properly pay you.
4. The patient must fill out *and* sign and date the Member Information section of the form.
5. Paper Medicare Part D Vaccine Claims should be submitted to: South Country Member Services, 6380 West Frontage Road, Medford, MN 55049, or faxed to 1-507-431-6328.

Member Name _____ **Member's Clinic ID#** _____

Medical Clinic Information

Clinic Name

Street Address

City State ZIP

Telephone ☐☐☐-☐☐☐-☐☐☐☐

National Provider ID Number _____

Prescribing Physician Information

Physician Name

Street Address

City State ZIP

Telephone ☐☐☐-☐☐☐-☐☐☐☐

National Provider ID Number _____

Provider Signature & Date

Provider Vaccine Rx Information

(Required information. Please submit one form per vaccine.) Indicate the NDC# from the box or package, not the vial. Please check the appropriate box for the vaccine received.

	Brand Name	Valid NDC#	Quantity	Days Supply	Date Administered	Vaccine Charge	CPT	Admin. Charge-90471
☐	Shingrix	58160081912	1	1			90750	
☐	Shingrix	58160082311	1	1			90750	
☐	Arexvy	58160084811	1	1			90679	
☐	Abrysvo	00069034401	1	1			90678	
☐	Abrysvo	00069034405	1	1			90678	

Any person who knowingly and with intent to defraud, injure or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent insurance act which is a crime and may be subject to criminal or civil penalties including fines and/or imprisonment, or denial of benefits.