Influenza Vaccine Reimbursement Form

Please use this form to obtain reimbursement if you received a flu shot or FluMist in a non-participating location. 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 _____

Amount paid for flu shot or FluMist _____

Location where you received the flu shot or FluMist _____

Date you received the flu shot or FluMist _____

Independence Blue Cross members with HMO, POS, and PPO plans can receive up to a $25 reimbursement by mailing this form and paid receipt to the address below.

Medicare Advantage members can receive reimbursement for the full out-of-pocket amount by mailing this form and paid receipt to the address below.

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

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

Independence

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