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 Blue Cross offers products directly, through its subsidiaries Keystone Health Plan East and QCC Insurance Company, and with Highmark Blue Shield — independent licensees of the Blue Cross and Blue Shield Association.