



**AmeriHealth**

# H1N1 Influenza Vaccine Reimbursement Form

Please use this form to obtain reimbursement if you received an H1N1 flu shot or nasal spray 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:**  H1N1 Flu shot  H1N1 nasal spray **Amount paid:** \_\_\_\_\_

**Location where you received the H1N1 flu shot or nasal spray:** \_\_\_\_\_

**Date you received the H1N1 flu shot or nasal spray:** \_\_\_\_\_

**Claims Department (internal use)**

Procedure Code #	Description
90470	H1N1 immunization administration
Diagnosis Code #	Description
V04.81	Prophylactic vaccination and inoculation influenza

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

**AmeriHealth Processing Center**  
P.O. Box 69357  
Harrisburg, PA 17106-9357