Flu and COVID-19 Vaccine

IMPORTANT: This form must be legible and completed entirely to be accepted.
Forms that are not completed or legible will be returned and payment will be delayed. Roster must be submitted within 180 days of service for reimbursement.

Employer Name:_____

Name of Clinic/Facility providing shots: _____ Name of Physician/PA: _____

Physical Address of Clinic/Facility providing shots: _____

Contact Person: _____ Phone Number: _____

Maximum allowed per shot is $26.00, or as defined by contract.

	Date of vaccine	Sanford Health Plan Member ID	Member Last Name	Member First Name	Date of Birth	Price of Shot	NDC #	CPT Code
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Payee (name of clinic/facility): _____ Tax ID# (REQUIRED) _____

Remittance address: _____ NPI # (REQUIRED) _____

Return form to:
Mail: Sanford Health Plan | Attn: Claims Department | PO Box 91110 | Sioux Falls, SD 57109-1110
Fax: (605) 328-6840 **Email:** clientservices@sanfordhealth.org

790-772-225 Rev. 09/21

SANFORD HEALTH PLAN