A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Member Flu Shot Reimbursement Form

Non-Medicare Blue Preferred PPO℠

Fill out (online or by hand), print, sign and mail this form with original receipts to:

Blue Cross Blue Shield of Michigan
Imaging and Support Services
Member Claims MC 0010
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

Patient's Enrollee ID The enrollee or member ID can be found on your Blue Cross ID card		
Alpha	Numeric	Group number

Member information		
Subscriber's last name	Subscriber's first name	
Subscriber's street address		
City	State	ZIP code

Patient's information	
Patient's last name	Patient's first name
Patient's date of birth	Sex M F

To process your request, please remember to:

- Complete one form for each enrollee.
- Mail only original clear itemized bill(s) on your provider's letterhead that include the following:
  - Your flu shot provider's logo, address, and phone number (for example - from a doctor, pharmacy or local health department)
  - Date of service
  - Amount paid
  - Vaccine name or description
- Keep copies of your original receipts for your files. We can’t return originals to you.

I certify the above information is true, the enclosed material is correct and unaltered, and the expenses were incurred by the enrollee listed above. False receipts or altering of this information will result in civil or criminal prosecution. I authorize the release of any information as described below.

Enrollee’s signature	Date	Phone

We value your privacy: We won't release any information about you unless you ask us to in writing or we must do so to process or review your claim (sharing with another insurance company, for example).We'll tell you which information we released and to whom, if you request it.