

<b>H1N1 Vaccine Administration Roster Bill</b>	<b>PROVIDER INFORMATION</b> Provider Name: _____
Header Information - information which is consistent for this entire listing.	Address: _____      Tax ID # : _____
<b>This Roster Bill <u>Must</u> Contain Information for only <u>One</u> Health Insurance Plan/Payor (listed below)</b>	City: _____      State: _____      Date Submitted: _____      Zip: _____
	<b>REMIT INFORMATION</b>
Payor Name: _____	Address: _____
Vaccine Code _____	City: _____      State: _____      Zip: _____
Administration Code _____	Contact Name: _____      Contact Phone# : _____
Diagnosis Code _____	DCN: _____

#	Patient Name							Insurance Information			Pharmacy Information			
	Last	First	Address	City	State	Zip	Date of Birth (MMDDYYYY)	Health Plan Member ID #	Group ID #	Patient Relationship Subscriber 02 - 01- Spouse 03 - Dependant	NPI (xxxxxxxx)	Claim Submitter's ID	Date of Service (MMDDYYYY)	Billed Charge
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Other Instructions: \_\_\_\_\_

10/14/09