County Health Department Claim Form

Health Care Trust

County Health Department Name:_____
County Health Department Address:_____
County Health Department Phone:_____
Tax ID#_____

Date of Service _____/_____/_____ **Total Amount $ _____**

Patient Name:_____DOB:_____

Address_____City_____Zip_____

Employee ID#_____Group ID#_____

Employee Name (if different from patient)_____

IMMUNIZATIONS

Childhood Vaccines		Service Provided √	Price	Adult Vaccines		Service Provided √	Price
Hepatitis B (Birth to 19)	V05.3 90744			Menomune (19+) Adult	V02.59 90733		
Pediarix (DTaP/IPV/Hepatitis B) Child	V20.2 90732			Menactra (2-55yrs)	V03.89 90734		
Prevnar 7 (pneumococcal)	V03.89			Twinrix (18+) Adult	V06.8 90636		
HIB	V03.8 90648			Hepatitis A (19+)	V05.3 90632		
Influenza (6mo to 35mo)	V04.8 90655			Hepatitis B (20+)	V05.3 90746		
Influenza (3 to <4 yrs)	V04.8 90656			Pneumovax/23 Adult	V03.82 90732		
Influenza (4 +yrs)	V04.8 90658			Proquad (ages 12 months to 12 years) Child	V06.8 90710		
FluMist (2-49 yrs)	V04.8 90660			TB Skin Test (PPD)	V01.1 86580		
MMR Child/ Adult	V06.4 90707			Polio	90712 90713		
Varicella Child/Adult	V05.4 90716			Td Adult	V06.5 90718		
DTap Child	V06.1 90700			Zoster Shingles vaccine (60+ yrs)	V04.8 90736		
Rotateq/Rotarix Child	V04.89 90861			HPV Vaccine, 3 dose schedule (9 yrs to <27)	V04.8 90649		
Td (Children over 7 years of age)	V06.5 90718			Immunization Administration (Single)	V04.8 90471		
Tdap (Boostrix) Child (10-18)	V06.1 90715			Immunization Administration (2 or more)	V04.8 90472		
Tdap (Adacel) 11-64 Child/Adult	V03.8 90715			Perrtacel (Child) (DTap/IPV/HIB)	V04.8 90698		
Ped DT Child	V06.8 90702						
Column Total				**Column Total**			

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO: _____
FOR SERVICES DESIGNATED ABOVE.

SIGNATURE(Insured or Authorized Person)_____

Please mail claim form to: **MACo Health Care Trust Claims, PO BOX 1966, Missoula MT 59806-1966**