University of Nebraska Omaha

Flu Shot
Health Insurance Claim Form

University of Nebraska Omaha, Health Services, 102 H&K
6001 Dodge Street, Omaha, NE 68182-0301 (402)554-2374

Directions:

Complete Sections 1-6

1. Name: Last First Middle Initial	**2. Date of Birth:** __ / __ / ___ (mo.) (day) (yr.) **Sex**: ☐ Male ☐ Female
3. Address: _____ City: _____ State: _____ Zip: _____ Telephone: (_____) __ __ __ - __ __ __ __	4**. Patient Relationship to Insured:** ☐ Self ☐ Spouse* ☐ Child* ☐ Other*

5. Insurance Company Name: _____ Insurance ID Number: _____ Group/Plan Number:_____

Insurance Company Address: _____ Insurance Company Phone Number:_____

***Complete the box below with the card owners name if you are the spouse, child or other of the insured**

Insured's Name (Last , First, MI)	
Insured's Address	
City	
Zip	Telephone ( )
Insured's date of birth ____ / ____ / _____ (mo.) (day) (yr.)	Insured's Sex ☐ Male ☐ Female
Employer's Name	Insurance Plan Name or Program:

6. Patient's Authorizing Signature: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or the party who accepts assignment below:

Signature:_____ Date _____

For Health Services Staff Only

CPT Procedure	Charges
90686 Influenza Vaccine-FLUARIX ® QUADRIVALENT	$25.00
90471 Administration	$10.00
Diagnosis Code: **Z23** **NDC-58160905-52**	Submit to Insurance: $35.00

Revised 9/22/17