

SANFORD HEALTH PLAN FLU SHOT ROSTER - 2009

Please complete this form entirely and PLEASE PRINT. Forms that are not legible will be returned and payment will be delayed.

Employer Name: _____

Name of Clinic/Facility providing shots: _____

Physical Address of Clinic/Facility providing shots: _____

Contact Person: _____ Phone Number: _____

Cost allowed per shot/flu mist \$20.00

#	Date of shot	Member Last Name	Member First Name	Sanford Health Plan Member ID (NOT SSN)	Date of Birth	Indicate Shot or Mist	Price of Shot/Mist	Sanford Heath Plan Member (Yes/No)
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
16								

Payee (name of clinic/facility): _____ Tax ID# (REQUIRED) _____

Remittance address: _____