

(County Name) _____ **County Health Department**
 Address: _____ City _____ Zip _____
 Phone: (406) _____ - _____
 Tax ID # _____ POS :71 County Insurance Receipt

Date of Service ____/____/____ **Total Amount \$** _____
 Client Name _____ DOB _____
 Address _____ City _____ Zip _____
 Employee ID# _____ Group ID# _____
 Employee Name (if different from client) _____

IMMUNIZATIONS

	Service Provided √ Price			Service Provided √ Price		
Hepatitis B (Birth to 19)	V05.3 90744			Menomune 2 to adult Child/Adult	V02.59 90733	
Pediarix (DTaP/IPV/Hepatitis B) Child	V06.8 90732			Menactra (19+) Adult	V03.89 90734	
Prevnar 7 (pneumococcal)	V03.82 90669			Twinrix (18+) Adult	V06.8 90636	
HIB	V03.81 90648			Hepatitis A 1 yr to adult Child/Adult	V05.3 90632	
Influenza (6mo to <3 yrs)	V04.81 90655			Hepatitis B (20+)	V05.3 90746	
Influenza (3 to <4 yrs)	V04.8 90656			Pneumovax/23 – 2 yr to adult Child/Adult	V03.82 90732	
Influenza (6 mo to 35 mo)	V04.81			Influenza (3+)	V04.8 90658	
Influenza (4+ yrs)	V04.81					
MMR Child/Adult	V06.4 90707			TB Skin Test (PPD)	V01.1 86580	
Varicella Child/Adult	V05.4 90716			Td Adult	V06.5 90718	
DTap Child	V06.1 90700			Zoster (Shingles) vaccine Age 60+	V05.8 90736	
Rotateq Child	V04.89 90680			HPV vaccine, 3 dose schedule Ages 9-26 yrs Child/Adult	V05.8 90649	
Td (Children over 7 years of age)	V06.5 90718			IPV Child	V04.0 90713	
Tdap (Boostrix) Child (10-18)	V06.1 90715			Immunization Administration (Single)	90471	
Tdap (Adacel) Child/Adult (11-64)	V03.8 90715			Immunization Administration (2 or more)	90472	
Ped DT Child	V06.8 90702			Immunization Administration (Oral/Intranasal)	90467	
Proquad (ages 12 months to 12 years) Child	V06.8 90710					
Column Total						

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THIS COUNTY HEALTH DEPARTMENT FOR SERVICES DESIGNATED ABOVE.

SIGNATURE (Insured or Authorized Person) _____

Please mail claim form to: First Choice Health—MUST
 P.O. Box 12569
 Seattle, WA 98111-4659