moda HEALTH

FLU SHOT CLINIC — GROUP BILLING FORM

Employer name _____ Date of service _____

Billing provider name _____ Immunization CPT code/price _____

Provider TIN/ NPI# _____ Administration CPT code/price _____

Please submit claims to: ODS Health Plans, Attn: Director Medical Claims, PO Box 40384, Portland OR 97240-0384

Member ID #	Last Name	First Name	Date of Birth	Gender M/F	Signature

- Please limit to one influenza product per page
- All fields must be populated and legible for claims to be processed

Updated 10-01-09