CoxHealth
MedicareAdvantage
by Cox HealthPlans

Flu Vaccination Reward Form

You are eligible to receive one $10 reward annually during the coverage year. Complete and return this form if your flu shot was received at a location other than your primary care physician's office. This includes a pharmacy, walk-in clinic, and health department. Rewards will be loaded on your Flex Card after verification of eligibility.

Member Name:
Member ID#:
Member DOB:
Date Vaccination Received:
Location Received:
Required Attachment (pick one): □ Documentation of received vaccine including date □ Receipt of received vaccine including date
Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. I verify that all information contained in this form is true, correct, and complete to the best of my knowledge. In order to process a claim for benefits I hereby authorize all individuals or institutions having information as to the care, advice, treatment, diagnosis, or prognosis of any physical or mental condition, or the financial and employment status, or the patient, employee, or named below, to provide this information to CoxHealth Medicare Advantage or any agent or independent administrator acting on its behalf (including records). I understand that I have the right to receive a copy of this authorization upon request. A copy of this shall be as valid as the original.

DATE:	**SIGNATURE OF BENEFICIARY OR AUTHORIZED REPRESENTATIVE:**

**Form needs to be completed in its entirety, including required items for verification of reward.*

Send form to:
CoxHealth Medicare Advantage
Attention Customer Service
P.O. Box 5750
Springfield, MO 65801-5750

INTERNAL ONLY	
DATE FORM RECEIVED:	BY: