# Missouri Consolidated Health Care Plan

## Plan #7670-00-410425 and #7670-02-410425

## Non-Network Vaccine Reimbursement Form

**Choose one of the following ways to submit this form, along with copies of your receipts:**

Fax: **855-405-2189**

Mail: **UMR**
**PO Box 8033**
**Wausau, WI 54402-8033**

**SUBSCRIBER NAME** _____

**SUBSCRIBER ID NUMBER** _____

**PATIENT NAME** _____

**DATE OF VACCINE** _____

**TYPE OF VACCINE**

- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ HPV (Human Papillomavirus)
- ☐ Influenza (Flu)
- ☐ Meningitis
- ☐ MMR (Measles, Mumps, Rubella)
- ☐ Pneumonia
- ☐ Polio
- ☐ Shingles
- ☐ Tetanus/Diptheria/Pertussis (Tdap)
- ☐ Tetanus/Diptheria (Td)
- ☐ Varicella
- ☐ Other_____

**UMR Use Only:**
**REIMBURSE THE SUBSCRIBER**

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