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