Blue Cross Blue Shield of Michigan

Blue Cross Blue Shield of Michigan Medicare Advantage Plans
INFLUENZA A (H1N1) IMMUNIZATION ROSTER*

Provider** Name: _____ Date of Service: _____

National Provider Identif cation Number: _____

Member Contract Number***	Last Name	First Name	Date of Birth (mm/dd/yyyy)	Sex M/F	Patient Address	Patient Signature

Clinic Location: _____ Nurse's Initials: _____

Submit one claim for each date of service.

* This roster is the property of Blue Cross Blue Shield of Michigan and is considered proprietary and conf dential.
** Provider must accept BCBSM payment as payment in full.
*** See the member's BCBSM Medicare Advantage ID card, do not use HIC numbers.

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