

# MENINGITIS VACCINATION REIMBURSEMENT AND INCENTIVE PROGRAM VACCINATION CERTIFICATE FORM



*Instructions: To receive reimbursement for the charges associated with the pneumococcal vaccine, please complete this form, attach a copy of your itemized bill and receipt for the unreimbursed medical expenses and mail or fax it to the below. Additional forms & information are found on [www.AdvancedBionics.com](http://www.AdvancedBionics.com).*

**Advanced Bionics; 28515 Westinghouse Place, Valencia, CA 91355; ATTN: Auditory Reimbursement Services  
Or fax to (866) 639-6190**

Patient Information (if child, to be completed by parent/guardian)		
Name	Date of Birth:	
Parent or Legal Guardian name:		
Address:		
City	State:	Zip Code:
Implantation Date(s):	Cochlear Implant Model(s):	
Phone:	Email	

## Pneumococcal Immunization Verification

Patient is under 2 years of age and has received the number of doses of Prevnar® 7-valent (or equivalent) pneumococcal conjugate vaccine (PCV) recommended by CDC for high-risk children:

1st Dose       2nd Dose       3rd Dose       4th Dose  
 Date: \_\_\_\_\_ Date: \_\_\_\_\_ Date: \_\_\_\_\_ Date: \_\_\_\_\_  
 Lot: \_\_\_\_\_ Lot: \_\_\_\_\_ Lot: \_\_\_\_\_ Lot: \_\_\_\_\_

Patient is 2 to 18 years of age and has received Pneumovax® 23-valent (or equivalent) pneumococcal polysaccharide vaccine (PPV) as recommended by CDC:

Initial Dose      Date: \_\_\_\_\_ Lot: \_\_\_\_\_  
 5-year 2nd Dose      Date: \_\_\_\_\_ Lot: \_\_\_\_\_

Patient is over 18 years of age and has received Pneumovax® 23-valent (or equivalent) pneumococcal polysaccharide vaccine (PPV) as recommended by CDC. Date: \_\_\_\_\_ Lot: \_\_\_\_\_

Physician's Office Information (to be completed by office where vaccinated)	
Physician Name:	
Phone number:	Date vaccination completed:
Physician Signature:	

**FOR ADVANCED BIONICS USE ONLY: UNREIMBURSED MEDICAL EXPENSES FOR PNEUMOCOCCAL VACCINE**

Payable to: \_\_\_\_\_

For Charge Account no: 2-7100-5015

Address is same as above

**Total Amount Due: \$** \_\_\_\_\_

Dataflow #: \_\_\_\_\_

Eligible for Vaccination Incentive Program (VIP)

Date: \_\_\_\_\_

Approved by: \_\_\_\_\_ Date: \_\_\_\_\_