SYSTEMSPLUS MUTUAL INSURANCE COMPANY
CRESTRON
GROUP #50655

Please Remit Plan Reimbursement to:
☐ Provider
☐ Employee

Attention CBA Blue Claims Examiner: *Flu Vaccines are to be reimbursed at the in-network level, not subject to reasonable and customary and reimbursed at 100%*

STATEMENT OF CLAIM FOR MEMBER ON-SITE FLU VACCINE	**FAX THIS FORM TO:** CBA BLUE ATTENTION: CAROL LEA P.O. BOX 2365 SO BURLINGTON, VT 05407-2365 FAX: 802-846-2755

PART I - TO BE COMPLETED BY EMPLOYEE

Patient Name	Relationship to Employee	Patient Birth Date
Employee Name	Participant ID# NFI	Employee Birth Date
Employee Mailing Address		

I certify that the statements on this form and all information furnished by me are true and complete to the best of my knowledge. I agree to permit any healthcare provider to release/disclose any information (including Protected Health Information) acquired in connection with any past or future care or treatment to CBA, Inc. dba CBABLUE., or its designated agent for purposes of administering healthcare coverage.

Employee Signature:

Date:

PART II - TO BE COMPLETED BY PROVIDER

Provider Name	Tax Identification Number
Provider Address	

Date of Service	Diagnosis	Procedure Code	Fee	Notes/Comment

Rev 1/1/2008

CBA Blue