

Claim Number:   
Received Date:   
*Office use only*

# Immunisation Benefit Claim Summary Form

*This form is to accompany any immunisation form on which a payment is claimed*

Send completed forms to: **IMMS, HealthPAC, PO Box 1043, WELLINGTON 6140**

Telephone 0800 458 448

## Details of Claimant

Claim Reference   
 Payee Number  Agreement Holder Name   
 Agreement Number  /

## Details of Practitioner

(  whichever is applicable)

Registration Number  Medical Council  Nursing Council   
 Surname or Last Name   
 First Name

## Details of Locum (if applicable)

Locum Registration Number   
 Surname or Last Name   
 First Name

## Summary Details of Claim

Number of Claim Details Forms attached   
 Dates of Service from  /  /  to  /  /

Claim Code	Description	Qty	Total Amt Claimed
IMOA	Administration of Standard Immunisation	<input type="text"/>	\$ <input type="text"/>
IMFA	Administration of Influenza Immunisation	<input type="text"/>	\$ <input type="text"/>
IMFV	Influenza Vaccine Subsidy	<input type="text"/>	\$ <input type="text"/>
IMMB	Administration of MeNZB Immunisation	<input type="text"/>	\$ <input type="text"/>

**TOTAL AMOUNT CLAIMED (GST Included)** \$

## Certification

I certify that this claim is in accordance with the Section 88 Advice Notice, PHO agreement or other approved agreement for immunisation services, and is for immunisation services provided by me personally or by a registered nurse in my practice within a programme approved by the Ministry of Health for which the vaccine has been supplied by an authorised agent of the District Health Board. I hereby claim the sum shown above on behalf of the patients listed on the attached detail forms. I have ticked the appropriate columns to indicate each specific immunisation given. This claim is in lieu of any other fee that I might otherwise be entitled to receive under the Section 88 Advice Notice for General Practitioners, PHO Agreement or other approved agreement.

Signature of Claimant  Date  /  /

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