



Christian Brothers Services Vaccine Reimbursement Form

If you received a flu shot or any other available vaccine at a pharmacy and you were required to pay for the vaccine out of your pocket, you will be reimbursed 100% of the cost of the vaccination under your Preventive Benefit. *

To receive reimbursement, please complete the information on this form and attach the provider's receipt.

Please provide all of the following:

ID# (found on the front of your Medical ID card) :	9 _ _ _ _ _
Indicate Relationship to Medical ID cardholder:	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child
First Name:	
Last Name:	
Street Address:	
City:	
State & Zip:	
Phone:	
Email:	

Attach Provider Receipt:

The receipt must reflect the **provider's name, the patient name, date of service, and amount paid**. If the receipt does not include the patient name, you must include a copy of the signed authorization form.

Send to:

**CBEBT Health Benefits
1205 Windham Parkway
Romeoville, IL 60446**

Reimbursement requests should be submitted within 90 days from date of service.

* Reimbursement subject to the terms and conditions of your plan. The complete terms of the plan are contained in the *Your Employee Benefits* booklet issued to members. For more information regarding benefits, please contact our customer service team at the number listed on the back of your Medical ID card.