

COVID-19 Vaccine Roster Form

Palmetto GBA
PO Box 100190
Columbia, SC 29202

Providers should not bill for the product if they receive it FREE.

Providers must use separate forms for COVID-19 Vaccine and Monoclonal Antibody COVID-19 Infusions.

Provider Name:	<input type="text"/>	Diagnosis Code	<input type="text"/>
NPI:	<input type="text"/>	COVID-19 Vaccine Code	<input type="text"/>
Date of Service:	<input type="text"/> (One date per roster)	Administration Code	<input type="text"/>

Patient Information (Please PRINT or TYPE all elements clearly except patient/beneficiary's signature)

Medicare Number:	<input type="text"/>	Date of Birth:	<input type="text"/>	Sex:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	
Last Name:	<input type="text"/>	First Name:	<input type="text"/>	Middle Initial	<input type="text"/>	<input type="checkbox"/>	
Address:	<input type="text"/>	City:	<input type="text"/>	State:	<input type="text"/>	Zip Code:	<input type="text"/>
Patient's Signature: _____ <input type="checkbox"/> Yes, if signature on file OR patient/beneficiary's signature							

Medicare Number:	<input type="text"/>	Date of Birth:	<input type="text"/>	Sex:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	
Last Name:	<input type="text"/>	First Name:	<input type="text"/>	Middle Initial	<input type="text"/>	<input type="checkbox"/>	
Address:	<input type="text"/>	City:	<input type="text"/>	State:	<input type="text"/>	Zip Code:	<input type="text"/>
Patient's Signature: _____ <input type="checkbox"/> Yes, if signature on file OR patient/beneficiary's signature							

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Last Name:	<input type="text"/>	First Name:	<input type="text"/>	Middle Initial	<input type="text"/>	<input type="checkbox"/>	
Address:	<input type="text"/>	City:	<input type="text"/>	State:	<input type="text"/>	Zip Code:	<input type="text"/>
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Address:	<input type="text"/>	City:	<input type="text"/>	State:	<input type="text"/>	Zip Code:	<input type="text"/>
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Address:	<input type="text"/>	City:	<input type="text"/>	State:	<input type="text"/>	Zip Code:	<input type="text"/>
Patient's Signature: _____ <input type="checkbox"/> Yes, if signature on file OR patient/beneficiary's signature							

For Medicare Recipients: Signature on File indicates, "I authorize the release of my medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment."

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