

Immunisation Benefit Claim Details Form

Claim summary details

Claim reference

Payee number

Details of patient

NHI number

Date of birth (DD/MM/YYYY)

Surname or family name

First name(s)

Details of service

Date of service (DD/MM/YYYY)

Claim codes (X those applicable)

- | | |
|---|---|
| <input type="checkbox"/> IMOA – Administration of standard Imm | <input type="checkbox"/> IMFA – Administration of influenza Imm |
| <input type="checkbox"/> IMZF – Zoster with Flu Co-Administration | <input type="checkbox"/> IMFV – Influenza Vaccine Subsidy |

Immunisation summary

Please write the indication and dose for each immunisation code being claimed.

See Claims Details Form Cover for Indication and Dose information.

Vaccine	Indication	Dose	Vaccine	Indication	Dose	Vaccine	Indication	Dose
BCG	<input type="text"/>	<input type="text"/>	Influenza	<input type="text"/>	<input type="text"/>	Rotavirus	<input type="text"/>	<input type="text"/>
DTaP-IPV-HepB/Hib	<input type="text"/>	<input type="text"/>	IPV	<input type="text"/>	<input type="text"/>	Td (ADT)	<input type="text"/>	<input type="text"/>
HBIG	<input type="text"/>	<input type="text"/>	Men ACWY	<input type="text"/>	<input type="text"/>	Tdap (aTap)	<input type="text"/>	<input type="text"/>
Hep A	<input type="text"/>	<input type="text"/>	Men B (4C MenB)	<input type="text"/>	<input type="text"/>	Varicella (vv)	<input type="text"/>	<input type="text"/>
Hep B Paed	<input type="text"/>	<input type="text"/>	Men CCV	<input type="text"/>	<input type="text"/>	Zoster (HZV)	<input type="text"/>	<input type="text"/>
Hep B Adult	<input type="text"/>	<input type="text"/>	MMR	<input type="text"/>	<input type="text"/>	Other	<input type="text"/>	<input type="text"/>
Hib	<input type="text"/>	<input type="text"/>	PCV10	<input type="text"/>	<input type="text"/>	Other	<input type="text"/>	<input type="text"/>
HPV	<input type="text"/>	<input type="text"/>	PCV13	<input type="text"/>	<input type="text"/>	Other	<input type="text"/>	<input type="text"/>
			PPV23	<input type="text"/>	<input type="text"/>			

Attach to the Claim Summary Form and send to **IMMS, Ministry of Health, PO Box 1026, Wellington 6140**
 Visit: health.govt.nz and search 'Immunisation Subsidy' Ph: 0800 855 066