Flu Vaccination Reimbursement Form

DeanHealthPlan by Medica

We'll reimburse you up to $33 for flu vaccinations administered by an out-of-network care provider. Remember, the seasonal flu vaccine also protects against H1N1. And you only need one vaccination.

Mail this completed form and a copy of your receipt to:

Dean Health Plan
P.O. Box 56099
Madison, WI
53705-9399

Please submit a separate form for each family member or dependent receiving a vaccine.

Member name _____

Member number (found on your ID card) _____

Member address _____

State ____ **ZIP**_____ **Date of birth**_____ **/** _____ **/**_____

Check one:

- ❍ Member is 0-3 years old
- ❍ Member is age 4 or older

Reimbursement can take 30-45 days from the date we receive this form. Vaccination charges that exceed $33 from an out-of-network provider are your responsibility. Flu vaccinations paid with flu vaccination gift cards aren't eligible for reimbursement.

Discrimination is Against the Law

The Health Plan complies with applicable Federal civil rights laws and will not discriminate against any person based on his or her race, color, creed, religion, national origin, sex, gender, gender identity, health status including mental and physical medical conditions, marital status, familial status, status with regard to public assistance, disability, sexual orientation, age, political beliefs, membership or activity in a local commission, or any other classification protected by law. The Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: TTY communication and written information in other formats such as large print, audio, and braille.
- Provides free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact the number on the back of your identification card. If you believe that we have failed to provide these services or discriminated in another way on the basis of your race, color, creed, religion, national origin, sex, gender, gender identity, health status including mental and physical medical conditions, marital status, familial status, status with regard to public assistance, disability, sexual orientation, age, political beliefs, membership or activity in a local commission, or any other classification protected by law, you can file a grievance with: Civil Rights Coordinator, Mail Route CP250, PO Box 9310, Minneapolis, MN 55443-9310, 952-992-3422, TTY: 711, civilrightscoordinator@medica.com.

You can file a grievance in person or by mail, fax, or email. You may also contact the Civil Rights Coordinator if you need assistance with filing a complaint. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201 800-368-1019, TTY: 800-537-7697. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

If you want free help translating this document, call 1-877-317-2410 (TTY: 711).

Si desea recibir asistencia gratuita para la traducción de este documento, llame al 1-877-317-2410.

Yog koj xav tau kev pab dawb txhais daim ntawv no, hu rau 1-877-317-2410.

如果您需要我們免費幫您翻譯此文件，請致電 1-877-317-2410。

Nếu quý vị muốn giúp dịch tài liệu này miễn phí, gọi 1-877-317-2410.

Sanadnikun kaffaltiimaleeakkaisiniifhiikamuyoobarbaadd-an 1-877-317-2410 tiinbilbilaa.

إذا كنت ترغب في مساعدة مجانية لترجمة هذا المستند، فاتصل على الرقم 1-877-317-2410.

Если вы хотите получить бесплатную помощь в переводе этого документа, позвоните по телефону 1-877-317-2410.

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອຟຣີໃນການແປເອກະສານນີ້, ໃຫ້ໂທຫາ 1-877-317-2410.

Si desea recibir asistencia gratuita para la traducción de este documento, llame al 1-877-317-2410.

Kung nais mo ng libreng tulong sa pagsasalin ng dokumentong ito, tumawag sa 1-877-317-2410.

이 문서를 번역하는 데 무료로 도움을 받고 싶으시면 1-877-317-2410로 전화하십시오.

Si vous désirez obtenir gratuitement de l'aide pour traduire ce document, appelez le 1-877-317-2410.

နမ့်လိဉ်ဘဉ်တ်မၤစၢၤကလိလၢတ်ကွဲးကျိာ်ထံလံာ်အံၤအဃိ, ကိး 1-877-317-2410.

ይህን ሰነድ ለመተርጎም ነጻ እርዳታ ከፈለጉ በ 1-877-317-2410 ይደውሉ።

Ako želite besplatnu pomoć za prijevod ovog dokumenta, nazovite 1-877-317-2410.

T'áá jiik'é díí naaltsoos t'áá nizaadk'ehjí bee shí ká'adoowoł ninízingo kojį' hodíílnih, 1-877-317-2410.

Wenn Sie kostenlose Hilfe zur Übersetzung dieses Dokuments wünschen, rufen Sie 1-877-317-2410 an.

"यदि आप इस दस्तावेज़ का अनुवाद करने में मुफ्त सहायता चाहते हैं, तो 1-877-317-2410 पर कॉल करें"।

Se desidera ricevere assistenza gratuita per la traduzione di questo documento, chiami il numero 1-877-317-2410.

Jeśli potrzebujesz bezpłatnej pomocy w przetłumaczeniu tego dokumentu, zadzwoń pod numer 1-877-317-2410.

اگر آپ اس دستاویز کا ترجمہ 1-877-317-2410 پر کال کریں کروانے کے لئے مفت مدد چاہتے ہیں، تو

COMIFB-1023-M