ptlmp 4/26/12

FORM 1
Reimbursement Request Claim Form

For The Maine Vaccine Board's
Provider Transitional Loss Mitigation Program (PTLMP)

Provider or
Provider Group: _____ **PCP:** _____
Mailing Address: _____ **NPI:** _____
_____ **EIN:** _____

City: _____ State: _____ Zip: _____

PCP: _____

Payee: (if different than Provider) _____ **NPI:** _____

Mailing Address: _____ **EIN:** _____

_____

City: _____ State: _____ Zip: _____

Vaccine Code	Quantity	Price

Vaccine Code	Quantity	Price

Mail To: **Maine Vaccine Board**
Provider Transitional Loss Mitigation Program (PTLMP)
PO Box 6794
Scarborough, ME 04070-6794
(for questions, call toll-free: 1-877-885-9788)

Email: _____

Prepared by: (Please Print) _____ Phone #: _____

_____ Date: _____
Preparer's Signature

_____ Date: _____
Signature of Company Officer:

FORM 2
Reimbursement Request Claim Detail

For The Maine Vaccine Board's
Provider Transitional Loss Mitigation Program (PTLMP)

Provider or
Provider Group: _____

PCP: _____
NPI: _____

Vaccine Code: _____
Quantity: _____

Patient ID	Date of Service	Date of Denial	Price

Vaccine Code: _____
Quantity: _____

Patient ID	Date of Service	Date of Denial	Price