ptlmp 4/26/12

FORM 1 - REFERENCE

Reimbursement Request Claim Form

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

Provider or
Provider Group: **(1)** **PCP:** **(2)**
Mailing Address: **(5)** **NPI:** **(3)**
EIN: **(4)**

City: State: Zip:

PCP: **(7)**
Payee: (if different than Provider) **(6)** **NPI:** **(8)**
Mailing Address: **(10)** **EIN:** **(9)**

City: State: Zip:

Vaccine Code (11)	Quantity (12)	Price (13)

Vaccine Code (11)	Quantity (12)	Price (13)

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: **(15)**

Prepared by: (Please Print) **(14)** Phone #: **(16)**

(17) Date: **(18)**
Preparer's Signature

(19) Date: **(20)**
Signature of Company Officer:

FORM 2 - REFERENCE

Reimbursement Request Claim Detail

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

Provider or
Provider Group: (1) _____

PCP: (2) _____
NPI: (3) _____

Vaccine Code: (21) _____
Quantity: (22) _____

Patient ID	Date of Service	Date of Denial	Price
(23)	(24)	(25)	(26)

Vaccine Code: (21) _____
Quantity: (22) _____

Patient ID	Date of Service	Date of Denial	Price
(23)	(24)	(25)	(26)