

Albright College

Inter-County — AmeriHealth Administrators

Group # _____

Flu Innoculation Reimbursement/Claim Form

Subscriber Name: _____

Subscriber ID# _____

Subscriber ID# _____ Date of Birth _____

Date of Service _____ Amount _____

Claim is being made for Self Covered Dependent

If covered dependent, please provide:

Name _____ Date of Birth _____

Member Signature

Home Phone

Work Phone

Attach receipt for flu innoculation and mail with completed form to:

Inter-County Health Plan
Attention: Claims
720 Blair Mill Road
Horsham, PA 19044