Claiming Reimbursement for Influenza Vaccination – Information for Consumers

Eligibility to claim reimbursement

Consumers are only eligible to claim reimbursement for influenza vaccination if all of the following criteria are met:

- Vaccination must have been received between 17 July and 31 August 2023.
- The consumer must provide proof of payment.

Submission Requirements

In order to claim reimbursement for privately purchased influenza vaccination, please submit the below to Queensland Health **prior to 30 September 2023**:

1. **Proof of purchase / tax invoice indicating the cost of the vaccine and the date.**
2. **Completed Reimbursement Claim form, including patient details and bank details for reimbursement.**

To ensure your invoice is efficiently processed, please ensure proof of purchase / tax invoice is forwarded to fluvaccine2023@health.qld.gov.au as a matter of priority. If proof of purchase does not contain patient details, details in the claim form will be used to confirm eligibility.

Reimbursement Claim Enquiries

For reimbursement enquiries, please contact fluvaccine2023@health.qld.gov.au.

2023 Influenza Vaccination Claim Form

Please complete the below form to capture consumer details for Influenza Vaccination Reimbursement.

Multiple consumers can be captured using the same form if the reimbursement location (bank account) is the same (i.e. families).

If reimbursement needs to go to different bank accounts, please use a separate form. If multiple forms need to be created from one consumer reference number, please ensure all forms are emailed together to fluvaccine2023@health.qld.gov.au.

Personal Details (Consumer Receiving Vaccination)

Full Name:	
Date of Birth:	
Address:	
Medicare Number:	/
Contact Phone Number:	

Details of Vaccination

Date (must be between 17/07/2023 and 31/08/2023 inclusive):	
Location of Vaccination:	
Total Cost of Vaccination/s:	

Details for Reimbursement

Account Name:	
BSB:	
Account Number:	

Form Completed By:_____ Date:_____

Queensland Government

Additional Consumers Claiming Reimbursement

Full Name:											
Date of Birth:											
Address:											
Medicare Number:										/	

Full Name:											
Date of Birth:											
Address:											
Medicare Number:										/	

Full Name:											
Date of Birth:											
Address:											
Medicare Number:										/	

Full Name:											
Date of Birth:											
Address:											
Medicare Number:										/	