



On-Site Flu Shot Clinic Roster

Member Entity Name: _____ Clinic Date: _____

	First Name	Last Name	Cigna Insurance Type			
	<i>(Please type or print)</i>	<i>(Please type or print)</i>	<i>Please check one</i>			
1			OAP	CF	INO	Not Covered
2			OAP	CF	INO	Not Covered
3			OAP	CF	INO	Not Covered
4			OAP	CF	INO	Not Covered
5			OAP	CF	INO	Not Covered
6			OAP	CF	INO	Not Covered
7			OAP	CF	INO	Not Covered
8			OAP	CF	INO	Not Covered
9			OAP	CF	INO	Not Covered
10			OAP	CF	INO	Not Covered
11			OAP	CF	INO	Not Covered
12			OAP	CF	INO	Not Covered
13			OAP	CF	INO	Not Covered
14			OAP	CF	INO	Not Covered
15			OAP	CF	INO	Not Covered
16			OAP	CF	INO	Not Covered
17			OAP	CF	INO	Not Covered
18			OAP	CF	INO	Not Covered
19			OAP	CF	INO	Not Covered
20			OAP	CF	INO	Not Covered
21			OAP	CF	INO	Not Covered
22			OAP	CF	INO	Not Covered
23			OAP	CF	INO	Not Covered
24			OAP	CF	INO	Not Covered
25			OAP	CF	INO	Not Covered

No. of OAP _____ No. of CF _____ No. of INO _____ No. Not Covered _____

Total No. of Flu Shots (This Page) _____ Cost per shot \$ _____

Employer: Please submit this roster for reimbursement of flu shots administered at your on-site flu shot clinic. Flu shots will be reimbursed up to \$25 each. If you have a Wellness Initiative Credit Account balance and would like to receive reimbursement for any amount above \$25, or for any non-covered individuals on this list including part-time employees, spouses, etc., please submit a Wellness Initiative Credit Program Reimbursement Application. Contact your MPR Benefits Advisor if you have any questions.