Completed by Pharmacy or The Little Clinic at Time of Redemption

Pharmacy/Store Acknowledgement:

I certify that services/materials above have been provided in good faith and in accordance with the requirements of this voucher and the accompanying physicians order and billed appropriately to any primary insurance providers as applicable.

Store/Division #_____ Date: _____/_____/_____

Signature of Store Employee:_____

Title (mark one) Pharmacist_____ Technician_____ Cashier/Clerk_____ TLC Provider_____

Total receipt amount billable to customer account above (may NOT exceed max value listed on voucher): $_____

Pharmacy and Store Instructions:

1. Voucher may be presented on participant's phone or by paper
2. Participant must have this Voucher, a commercial driver's license (CDL) and/or a Photo ID to be eligible.
3. Enter third party name VACCINE ROSTER BILLING-MEDIMPT (4001971) in the third party tab of the patient's profile
   - BIN: 012882 PCN: KPP
   - Input the cardholder id. 2001GO
   - The group ID field is hardcoded to always send KS001.
4. The claim will process with a zero copay
5. Retain completed voucher in store until August 1st following the expiration date. Shred after this date.

The Little Clinic Instructions:

1. Voucher presented by phone or paper and CDL to receive services.
2. For insurance and fee schedule select: **St. Christopher Fund.**
3. Enter patient into EMR following normal procedures by merging the correct template -
   - St. Christopher Fund Quadrivalent Vaccination Template (CPT code STCHF, 90686, 90687 & 90471)
   - St. Christopher Fund Pneumovax Vaccination Template (CPT code STCHF, 90732 & 90471)
   - St. Christopher Fund Zostavax Vaccination Template (CPT code STCHF, 90736 & 90471)
4. Scan the voucher into EMR or if by phone enter "St. Christopher Fund" Voucher" in billing notes on the appointment screen.
5. With this voucher there is no co-pay or out-of-pocket cost.

Card Holder ID # 2001GO
Group ID # KS001
Date of Birth ___/___/____
Issue Date: 09/01/2017

KROGER WELLNESS CUSTOMER

PHARMACY VOUCHER

Expiration Date: (03/31/2018)

*This Voucher is authorization to provide the customer below the approved service/products not in excess of the amounts specified below. A valid order must be received. This voucher has **no cash value** to the beneficiary and may only be redeemed for pharmacy prescription medication, immunizations or clinical health services. Any balance due in excess of the value of this voucher must be paid by the customer at the time of sale. This voucher may NOT be used in combination with any other third party pharmacy discount program.*

Beneficiary/Patient Name:

Authorized Services/Products: TIV Flu Vaccine, QIV Flu Vaccine, Zostavax Vaccine, Pneumovax Vaccine
All other services/products are not authorized.

Beneficiary/Customer Acknowledgement: *My signature below indicates that I received the products/services authorized by this voucher. I certify that I provided proof of any applicable primary insurance. I understand that the entity identified above will be responsible for payment on my behalf. I also understand that a minimum amount of PHI may be disclosed as part of the billing process to the above entity.*

Customer Name:_____

Customer Signature:_____ Date:_____/_____/_____

Customer Must Submit This Prescription Voucher At Time of Purchase in The Pharmacy

Clinical Services are not available at all pharmacies –

(Store Information on reverse side)