FIRST COAST
SERVICE OPTIONS, INC.
WHEN EXPERIENCE COUNTS & QUALITY MATTERS

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

COVID-19 Vaccines or Monoclonal Antibody Infusion Roster Form (See NOTE below)

Provider Name	National Provider Identifier (NPI)	Date of Service MM/DD/YYYY (One date per roster)

Patient Information (please PRINT all elements clearly except for beneficiary's signature)

Medicare ID	Date of Birth MM/DD/YYYY	Patient Signature or Signature on file

Last Name	First Name	MI	Sex: M/F

Address (No., Street)	City	State	Zip

Patient Information (please PRINT all elements clearly except for beneficiary's signature)

Medicare ID	Date of Birth MM/DD/YYYY	Patient Signature or Signature on file

Last Name	First Name	MI	Sex: M/F

Address (No., Street)	City	State	Zip

Patient Information (please PRINT all elements clearly except for beneficiary's signature)

Medicare ID	Date of Birth MM/DD/YYYY	Patient Signature or Signature on file

Last Name	First Name	MI	Sex: M/F

Address (No., Street)	City	State	Zip

Patient Information (please PRINT all elements clearly except for beneficiary's signature)

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Patient Information (please PRINT all elements clearly except for beneficiary's signature)

Medicare ID	Date of Birth MM/DD/YYYY	Patient Signature or Signature on file

Last Name	First Name	MI	Sex: M/F

Address (No., Street)	City	State	Zip

NOTE: Submit form for either COVID-19 vaccines or monoclonal antibody (mAb) infusions. Do not combine both on the same form. Also, Medicare will not provide payment for the COVID-19 vaccine or mAb products that health care providers receive for free.