

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)					
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.