GSK Vaccines Reimbursement Support Center

INSURANCE CHECKUP™ SUBMISSION FORM

Product Information

Vaccine Name: SHINGRIX		
NDC (if available): 58160-823-11	ICD-10 Code: Z23	CPT Code: 90750

Physician Information

Physician Name:		Practice Name: Steven M. Pounders, M.D., PLLC		
Street Address: 3500 Oak Lawn Ave, Ste 600		City: Dallas	State: TX	ZIP: 75219
Phone: 214-520-8833	Fax: 214-520-2956	E-mail:	Office Contact:	
NPI:		PTAN (Medicare Only):	Tax ID:	

Patient Information

First and Last Name:			
Phone:	Date of Birth: ______ /______ /______	○ Male	○ Female
Street Address:	City:	State:	ZIP:

Insurance Information (Attach copy, front and back, of patient insurance cards)

Primary Medical Insurance Name or Medicare Part D Plan Name:	Phone:
Subscriber Name:	Relationship to Patient:
Subscriber ID #:	Group ID #:

Application Checklist

- ❑ **Page 1 of Enrollment form Completed**
- ❑ **Complete & sign (signature of either patient or HCP/ Covered Entity Authorized Representative is required)**
  - ○ **Section 1 (Patient Signature)**

    OR
  - ○ **Section 2 (signature of HCP/Covered Entity Authorized Representative)**
- ❑ **Fax both pages of the form to GSK Vaccines Reimbursement Support Center upon completion to 877-683-1329 and please call 855-636-8291 with any questions.**