**Immunisation Benefit Claim Summary Form**

This form is to accompany any immunisation form on which a payment is claimed.

Send completed forms to: IMMS, Ministry of Health, PO Box 1043, WELLINGTON 6140

Telephone 0800 458 448

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### Details of Claimant

- **Claim Reference**
- **Payee Number**
- **Agreement Number** / Agreement Holder Name

### Details of Practitioner

- **Registration Number**
- **Surname or Last Name**
- **First Name**
- **Medical Council**
- **Nursing Council**

### Details of Locum (if applicable)

- **Locum Registration Number**
- **Surname or Last Name**
- **First Name**

### Summary Details of Claim

- **Number of Claim Details Forms attached**
- **Dates of Service from** / / / to / / /

<table>
<thead>
<tr>
<th>Claim Code</th>
<th>Description</th>
<th>Qty</th>
<th>Total Amt Claimed</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMOA</td>
<td>Administration of Standard Immunisation</td>
<td></td>
<td>$ .</td>
</tr>
<tr>
<td>IMFA</td>
<td>Administration of Influenza Immunisation</td>
<td></td>
<td>$ .</td>
</tr>
<tr>
<td>IMFV</td>
<td>Influenza Vaccine Subsidy</td>
<td></td>
<td>$ .</td>
</tr>
<tr>
<td>IMMB</td>
<td>Administration of MeNZB Immunisation</td>
<td></td>
<td>$ .</td>
</tr>
</tbody>
</table>

**TOTAL AMOUNT CLAIMED (GST Included)** $ .

### Certification

I certify that this claim is in accordance with the Section 88 Advice Notice, PHO agreement or other approved agreement for immunisation services, and is for immunisation services provided by me personally or by a registered nurse in my practice within a programme approved by the Ministry of Health for which the vaccine has been supplied by an authorised agent of the District Health Board. I hereby claim the sum shown above on behalf of the patients listed on the attached detail forms. I have ticked the appropriate columns to indicate each specific immunisation given. This claim is in lieu of any other fee that I might otherwise be entitled to receive under the Section 88 Advice Notice for General Practitioners, PHO Agreement or other approved agreement.

**Signature of Claimant**

**Date** / / /