PALMETTO GBA®
A CELERIAN GROUP COMPANY

COVID-19 Vaccine Roster Form

JJ-MAC Palmetto GBA
PO Box 100306
Columbia, SC 29202-3306

Providers should not bill for the product if they receive it FREE.
Providers must use separate forms for COVID-19 Vaccine and Monoclonal Antibody COVID-19 Infusions.

Provider Name: ______

NPI: ______

Date of Service: ______ (One date per roster)

Diagnosis Code ______

COVID-19 Vaccine Code ______

Administration Code ______

Patient Information (Please PRINT or TYPE all elements clearly except patient/beneficiary's signature)

Medicare Number: ______ Date of Birth: ______ Sex: ☐ Male ☐ Female

Last Name: ______ First Name: ______ Middle Initial ______

Address: ______ City: ______ State: ______ Zip Code: ______

Patient's Signature: ______ ☐ Yes, if signature on file OR patient/beneficiary's signature

Medicare Number: ______ Date of Birth: ______ Sex: ☐ Male ☐ Female

Last Name: ______ First Name: ______ Middle Initial ______

Address: ______ City: ______ State: ______ Zip Code: ______

Patient's Signature: ______ ☐ Yes, if signature on file OR patient/beneficiary's signature

Medicare Number: ______ Date of Birth: ______ Sex: ☐ Male ☐ Female

Last Name: ______ First Name: ______ Middle Initial ______

Address: ______ City: ______ State: ______ Zip Code: ______

Patient's Signature: ______ ☐ Yes, if signature on file OR patient/beneficiary's signature

Medicare Number: ______ Date of Birth: ______ Sex: ☐ Male ☐ Female

Last Name: ______ First Name: ______ Middle Initial ______

Address: ______ City: ______ State: ______ Zip Code: ______

Patient's Signature: ______ ☐ Yes, if signature on file OR patient/beneficiary's signature

Medicare Number: ______ Date of Birth: ______ Sex: ☐ Male ☐ Female

Last Name: ______ First Name: ______ Middle Initial ______

Address: ______ City: ______ State: ______ Zip Code: ______

Patient's Signature: ______ ☐ Yes, if signature on file OR patient/beneficiary's signature

For Medicare Recipients: Signature on File indicates, “I authorize the release of my medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment.”

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