



# Providers VAX Secure Invoice Upload

Tracking Number  
**638**

Date  
**6/15/2021**

## Contract Information

Please enter the contract number first to automatically populate the fields listed with an asterisk (\*) Please note that these fields are "Read Only" and edits are not permitted on the form.

**OTH-VAX-259**      **F. Marion Dwight, MD, PA**      **57-0704514**      **SC62183**  
 Contract Number (required)      \* Contractor Name      \* Tax ID      \* SCEIS Number

**Danette F McAlhaney, MD**      **President**      **(803) 245-5168**      **dfralix@aol.com**  
 Contact (Full Name)      Title      Phone      EXT      Contact EMAIL

**2113 Main Hwy**      **Bamberg**      **SC**      **29003**  
 \* Address      \* STE #      \* City      \* State      \* Zip

| INVOICE NUMBER | INVOICE AMOUNT |
|----------------|----------------|
| <b>55</b>      | <b>30.00</b>   |

## Please Upload Invoice for Payment Review

To ensure prompt processing of your invoice ensure that you include the invoice number in the file name that you upload. Please ensure that all required information is included on the invoice. Click below for more details

## Secure Document Upload

Please upload the invoice PDF to our secure website using the buttons below.

VACCINE REIMBURSEMENT INVOICE # 55

I certify that no other funds have been received or will be reimbursed by any other source for the amounts claimed on this invoice

Signature (required) Click to Sign

*Danette F McAlhaney, MD*  
 6/15/2021 12:08:02 PM

**\$30.00**  
 Invoice Total       Yes       No

**The attached invoice is accurate and the invoice total is correct.**

ACC Testing Approval

*Bonner, Melissa*  
 6/17/2021 9:39:30 AM

Budget and Finance Approval

*Samuels, Tierra B.*  
 6/22/2021 3:42:59 PM

Approved Funding \_\_\_\_\_

Approved Invoices to Date \_\_\_\_\_

Available Funding **\$0.00**

### Payment Processing Instructions

|                     |            |              |            |
|---------------------|------------|--------------|------------|
| Full Amount \$30.00 | 31070000   | Not Relevant | J0402AZ998 |
| J040X01058580130    | 5021310000 | 98000018     |            |

### Accounts Payable Approval

*Robinson, Sharon D.*  
 6/23/2021 12:11:57 PM



If rejecting this form for any reason please provide a brief note to the agency. It will be included in the rejection email notification

## COVID-19 Vaccination Reimbursement Request

### Community Vaccination Event Information\*

|                              |                                    |
|------------------------------|------------------------------------|
| Provider Name:               | DANETTE F MCALHANEY, MD            |
| COVID-19 Vaccine Pin Number: | 105051                             |
| Location Name:               | F MARION DWIGHT, MD, PA            |
| Location Address (incl zip): | 2113 MAIN HWY<br>BAMBERG, SC 29003 |
| Date & Times:                | 06-09-2021 11:00 AM -11:30 AM      |
| Total # Vaccinations:        | 1                                  |
| Eligible Vaccinations**:     | 1                                  |

Please select yes or no to the following questions to determine eligible reimbursement:

|            |   |
|------------|---|
| <u>Yes</u> | Did your organization provide event management, traffic control and logistics for this event? |
| <u>Yes</u> | Did your organization provide administrative staff for this event?                            |
| <u>Yes</u> | Did your organization provide vaccination staff for this event?                               |

### Reimbursement Calculator

| Item                                    | Rate | Eligible Event Reimbursement |
|---|------|------------------------------|
| Event Mgmt, Traffic, Logistics          | \$10 | \$10                         |
| Administrative Staff                    | \$5  | \$5                          |
| Vaccination Staff                       | \$15 | \$15                         |
| <b>Total Event Reimbursement Amount</b> |      | <b>\$30</b>                  |

### Additional Cost Summary\*\*\*:

|                                   |            |
|-----------------------------------|------------|
| Total additional cost:            |            |
| Less other funding/reimbursement: |            |
| Net additional cost:              | <b>\$0</b> |

**Total Request Amount: \$30**

\* Community Vaccination Events may span multiple days as long as the event location remains the same. All dates should be specified.

\*\* If seeking third-party reimbursement for the services at the event was not appropriate or feasible, then all vaccinations are eligible for reimbursement. If billing third party payers was feasible, then only vaccinations not eligible for insurance reimbursement are eligible for Staffing Reimbursement.

\*\*\* Claiming additional costs requires detailed justification and documentation. Please attach answers to the following questions: