Providers VAX Secure Invoice Upload

Tracking Number: **894**

Date: **8/18/2021**

Contract Information

Please enter the conract 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.

Contract Number (required)	* Contractor Name	* Tax ID	* SCEIS Number
OTH-VAX-195	**Fairfield Medical Associates, PA**	**57-0726632**	**223**

Contact (Full Name)	Title	Phone	EXT	Contact EMAIL
liz mann	**Practice Manager**	**(803) 635-6461**		**liz.mann@fairfieldmedical.org**

* Address	* STE #	* City	* State	* Zip
PO Box 1218		**Winnsboro**	**SC**	**29180**

INVOICE NUMBER	INVOICE AMOUNT
7-30	**30.00**

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 bu ons below.

COVID19 Vaccine Reimbursement Calculator (1)

☑ 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

liz mann
8/18/2021 1:35:33 PM

$30.00
Invoice Total

◉ Yes
○ No

The attached invoice is acurate and the invoice total is correct.

ACC Testing Approval

Bonner, Melissa
8/24/2021 12:33:38 PM

Budget and Finance Approval

Samuels, Tierra B.
8/27/2021 12:23:19 PM

Approved Funding

Approved Invoices to Date

Availible Funding **$0.00**

Payment Processing Instructions

Full Amount $30.00	31070000	Not Relevant	J0402AZ998
J040X01058580130	5021310000	98000018	

Accounts Payable Approval

Robinson, Sharon D.
8/27/2021 1:04:57 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

Inv. 7-30

Community Vaccination Event Information*

Provider Name: Fairfield Medical Associates

COVID-19 Vaccine Pin Number: SCA0119A

Location Name: Fairfield Medical Associates

Location Address (incl zip): Drive Thur Fairfield Medical

880 West Moultrie Street

Date & Times: 7/30/2021

Total # Vaccinations: 1

Eligible Vaccinations**: 1

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

Yes — Did your organization provide event management, traffic control and logistics for this event?

Yes — Did your organization provide administrative staff for this event?

Yes — Did you 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
Total Event Reimbursement Amount		**$30**

Additional Cost Summary***:

Total additional cost: 0

Less other funding/reimbursement: 0

Net additional cost: **$0**

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:

1) Summary Description of Request and Costs
2) Describe Benefit to the State of South Carolina and Statewide Vacinnation Efforts including the future distribution and administering of vaccines.
3) Describe activities conducted and outcomes expected or achieved
4) Is the cost being covered by any other funding source or insurance? Please explain.
5) Were all avenues of funding exhausted before using Vaccine Reserve Account funds? Please explain.