



# Providers VAX Secure Invoice Upload

Tracking Number  
**626**

Date  
**6/14/2021**

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

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

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

| INVOICE NUMBER | INVOICE AMOUNT |
|----------------|----------------|
| 6-3            | 120.00         |

## 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 buttons 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*  
6/14/2021 10:48:15 AM

**\$120.00**  
 Invoice Total       Yes       No

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

ACC Testing Approval

*Bonner, Melissa*  
6/14/2021 11:36:29 AM

Budget and Finance Approval

*Samuels, Tierra B.*  
6/16/2021 4:01:20 PM

Approved Funding

Approved Invoices to Date

Available Funding

**\$0.00**

Payment Processing Instructions

Full Amount \$120.00      31070000      Not Relevant      J0402AZ998  
 J040X01058580130      5021310000      98000018

Accounts Payable Approval

*Robinson, Sharon D.*  
6/18/2021 10:52:14 AM



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:               | Fairfield Medical Associates ( Inv. 6 - 3 )              |
| COVID-19 Vaccine Pin Number: | SCA0119A   |
| Location Name:               | Fairfield Medical Associates                             |
| Location Address (incl zip): | Drive Thur Fairfield Medical<br>880 West Moultrie Street |
| Date & Times:                | 6/3/2021   |
| Total # Vaccinations:        | 4  |
| Eligible Vaccinations**:     | 4  |

## 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 you organization provide vaccination staff for this event?                                |

## Reimbursement Calculator

| Item                                    | Rate | Eligible Event Reimbursement |
|---|------|------------------------------|
| Event Mgmt, Traffic, Logistics          | \$10 | \$40                         |
| Administrative Staff                    | \$5  | \$20                         |
| Vaccination Staff                       | \$15 | \$60                         |
| <b>Total Event Reimbursement Amount</b> |      | <b>\$120</b>                 |

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

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

**Total Request Amount: \$120**

\* 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 Vaccination 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.