



# Providers VAX Secure Invoice Upload

Tracking Number

**1363**

Date

**12/29/2021**

## Contract Information

AP REC 1/13/2022

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.

<u>oth-vax-268</u>	<u>Mackey Family Practice, PA</u>	<u>57-1008067</u>	<u>7000029711</u>
Contract Number (required)	* Contractor Name	* Tax ID	* SCEIS Number

<u>Kerri Hatcher</u>	<u>MD</u>	<u>(803) 285-7414</u>	<u>kerrih@mackeyfamilypractice.com</u>
Contact (Full Name)	Title	Phone	EXT Contact EMAIL

<u>1025 W Meeting St, Suite #200</u>	<u>Lancaster</u>	<u>SC</u>	<u>29720</u>
* Address	* STE #	* City	* State * Zip

<b>INVOICE NUMBER</b>	<b>INVOICE AMOUNT</b>
<u>12232021IL</u>	<u>320.00</u>

## 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 12232021 IL

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

*Kerri Hatcher*  
12/29/2021 10:41:36 AM

\$320.00  
Invoice Total

Yes  
 No

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

ACC Testing Approval  
*Bonner, Melissa*  
1/11/2022 11:47:46 AM

Budget and Finance Approval  
*Samuels, Tierra B.*  
1/12/2022 2:57:24 PM

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

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

Available Funding \$0.00

### Payment Processing Instructions

Full Amount \$320.00 31070000 Not Relevant J0402AZ998  
J040X01058580130 5021310000 98000018

### Accounts Payable Approval

*Cate, Vasa*  
1/12/2022 4:40:11 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

[Empty text box for rejection note]

# COVID-19 Vaccination Reimbursement Request

## Community Vaccination Event Information\*

Provider Name:	Mackey Family Practice
COVID-19 Vaccine Pin Number:	129114
Location Name:	Mackey Family Practice- Indian Land
Location Address (incl zip):	8351 Charlotte HWY Indian Land SC 29707
Date & Times:	12/20/2021 - 12/23/2021, 0900-1500
Total # Vaccinations:	28
Eligible Vaccinations**:	2

## 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	\$280
Administrative Staff	\$5	\$10
Vaccination Staff	\$15	\$30
<b>Total Event Reimbursement Amount</b>		<b>\$320</b>

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

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

**Total Request Amount: \$320**

\* 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: