Member Claim Form for Reimbursement of Over-the-Counter COVID-19 Tests for Personal Use

COMMUNITY CARE HEALTH

MEMBER INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address: _____ City: _____ State: _____ ZIP: _____

Home/Cell Phone: _____ Work Phone: _____ Date of Birth (MM/DD/YYYY): _____

Member ID #: _____ Employer: _____ Group #: _____

Test was purchased for use by (check one): ☐ Self ☐ Dependent covered under my benefit plan

If test was purchased for use by a Dependent covered under your benefit plan, provide the Dependent's information below:

Last Name: _____ First Name: _____ Middle Initial: _____

Member ID #: _____ Date of Birth (MM/DD/YYYY): _____

CLAIM INFORMATION

Product Name: _____ Manufacturer: _____

UPC: _____ [Note: The UPC, or Universal Product Code, is the 12-digit number under the bar code on the test package.]

Please indicate the total # of tests purchased: _____ [Note: Some test packages contain 2 tests.]

Date of Purchase: _____ Cost: $ _____

INSTRUCTIONS

Original receipt(s) must be included in order to receive reimbursement. The receipt(s) must clearly indicate the name of the seller, date of the purchase and identify the item(s) and quantity purchased. Only tests that have been authorized by the FDA to be completely used and processed at home are eligible for reimbursement. Coverage is limited to 8 tests per person per month.

Please send this completed claim form and receipt(s) to:

Community Care Health
Attn: COVID Test Reimbursement
P.O. Box 45026
Fresno, CA 93718

If you have any questions or require assistance in completing this form, please call 1 (855) 343-2247.

ATTESTATION

I certify that, to the best of my knowledge, the information on this Member Claim Form is true and correct. I further certify that each test was purchased by me for my personal use or the use of a Dependent covered under my benefit plan, was not for employment purposes, has not been (and will not be) reimbursed by another source, and is not for resale.

X _____ _____ _____

Signature | Print Name | Date