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



MemBER INFORMATION Last Name:						
Street Address: City:						
Home/Cell Phone:						
Member ID #:						
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: Middle Initial: Member ID #: Date of Birth (MM/DD/YYYY): CLAIM INFORMATION Product Name: Manufacturer: 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 a 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 45016 Fresno, CA 93718 If you have any questions or require assistance in completing this form, please call (559) 724-4995 or toll-free at 1 (844) 516-0181. 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.	Home/Cell Phone:	Work Phone: Da		Date of Birth (MM/DD/Y)	YYY):	
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		F	Print Name		Date	