



At-Home COVID Test

Reimbursement Claim Form

- ❖ Members can be reimbursed for at-home over-the-counter test kits beginning January 15, 2022. See below guidelines when submitting for reimbursement...
 - Test kits must have been **purchased on or after the January 15, 2022** effective date.
 - Proof of purchase **must include a date of purchase**.
 - The Plan will reimburse a **maximum of 8 tests per enrollee per month**. This will be based on the number of tests contained within a kit, in other words, if a test kit contains 2 tests, this will count as reimbursement of 2 units.
 - Make sure all of your documents being submitted are clear and legible to avoid any delay in processing your reimbursement.
 - Failure to submit reimbursement requests within 180 days after the date of service will result in a denial for reimbursement.

Instructions:

1. Complete sections 1 – 4 (one form per member) and sign and date the member signature line.
2. Attach the proof of purchase (receipt) which includes the purchase date, a description of the product and the amount paid.
3. Email, Fax, or Mail this completed form and the attachments to:

Ventura County Health Care Plan
c/o Care Reimbursements
2220 E. Gonzales Road, Suite 210-B, Oxnard, CA 93036
Fax: 805-981-5051 Email: VCHCP.Memberservices@ventura.org

If you have any additional questions or concerns, please contact us at the above or call us at (805) 981-5050 or (800) 600-8247.



1. Enrollee Information:

Name: _____ Date of Birth: _____
 (First) (Middle) (Last)
 Member ID #: _____ Email: _____

2. Employee (Subscriber) Information:

Name: _____ Employee # (Optional): _____
 (First) (Middle) (Last)
 Home Phone: _____ Work Phone: _____ E-mail (Optional): _____

3. Type of Service Performed (Please select one of the following)

At-Home COVID Test Other: _____

4. Purchase Information:

Purchase Date	Product Description	Cost
____/____/____		\$ _____
____/____/____		\$ _____
____/____/____		\$ _____
____/____/____		\$ _____
____/____/____		\$ _____
____/____/____		\$ _____
____/____/____		\$ _____
____/____/____		\$ _____

Indicate here if the check should be issued to the patient rather than the subscriber.

I certify that the foregoing information is accurate, complete and I have not been previously compensated for such services. I understand that the claim must be submitted to the Ventura County Health Care Plan within 180 days after the date of service.

Member Signature

Print Name

Date