At Home Over-the-Counter (OTC) COVID-19 Test Claim Form
Direct Member Reimbursement

This claim form can be used to request reimbursement of covered expenses for OTC COVID-19 test kits authorized by the federal Food and Drug Administration (FDA) for covered members under the plan.

This form is only to be utilized for OTC COVID-19 test kits. Forms missing information may be denied, delayed, or returned. If you need assistance completing this form, please call the MedOne help desk phone number on your member ID card.

Part 1: For whom was the OTC COVID-19 Test kit purchased?

1. Complete Part 1 for the member who has or will use the test kit.
2. Submit a separate form for each Member who has/will use the test kit and is requesting reimbursement.

First Name	Last Name	MI
Date of Birth	Phone Number	
ID Number (from member ID card)	Group # (from member ID card)	
Mailing Address		
City	State	ZIP Code

Part 2: Where was the OTC COVID-19 Test purchased?

Pharmacy/Online/Retailer Name	Telephone Number
Street Address (or Website Address)	
City, State, ZIP	Date of Purchase
How many test kits were purchased?	Product UPC or National Drug Code (NDC) (typically 11 digits and by the bar code)
Product Name	Member Paid Amount

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Part 3: Receipt Information

1. Include original Pharmacy/Online/Retailer receipt(s) or printout(s) for each test purchased.
2. Receipts will not be returned, remember to keep a copy of this completed claim form and receipt(s) for your records.

Part 4: Signature

I certify that all the information on this form is accurate, and the OTC COVID-19 test was purchased for personal use for a covered member under the prescription plan, not for employment purposes, has not been (and will not be) reimbursed by another source, and is not for resale.

Member Signature	Date Signed

Mail this completed form along with receipts to:
MedOne
1590 University Avenue
Dubuque, IA 52001

OR

Fax this completed form along with receipt(s) to:
563-588-8725