OTC-COVID 19 At Home Test Claim Form

Direct Member Reimbursement

This claim form can be used to request reimbursement of covered expenses.

Part 1: Member Information

1. Complete ALL information. Your ID Number can be located on your member ID card.
2. Submit claims within the filing period specified by your Benefit plan. For questions about your filing period please review your Member handbook or call the Customer Care number on your member ID card.
3. Please submit a separate form for each patient for which you purchased medications.
4. Reimbursement will be made directly to the CARDHOLDER unless otherwise noted.

First Name	Last Name	MI
Telephone Number ( )	Date of Birth	Gender (Circle One) Male Female
ID Number	Subscriber's Employer (PCN)	
Mailing Address		
City	State	ZIP Code
Member Signature		Date Signed

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

1. Complete ALL information.
2. Please submit a separate form for each distributor from which you purchased the OTC COVID 19 Test.

Pharmacy/Online/Retailer Name		Telephone Number ( )
Street Address		
City	State	ZIP Code

Part 3: Receipt Information

1. Include original receipt(s) or printout(s); Tape original receipt(s) to bottom of this page. *Please* DO NOT staple.
2. Receipt(s) must contain the information outlined under Part 3. If your receipt(s) are missing any of this information please fill in the missing information under Part 3.

OTC-COVID 19 At Home Test Claim Form

Direct Member Reimbursement

3. Receipts will not be returned, remember to keep a copy of the completed claim form and receipt(s) for your records.

Date of Purchase	Product Name
National Drug Code (NA if the code is not available)	Quantity of COVID Test/s in package
Original Cost	Member Paid Amount

Mail, Fax, or Email this form along with receipts to:

Navitus Health Solutions
P.O. Box 999
Appleton, WI 54912-0999 OR

Fax: (920)735-5315 / Toll Free (855)668-8550 OR

Email: ManualClaims@Navitus.com