Covid Home Test Paper Claim Form

Please complete and return this form when you have purchased a Covid Home Test Kit at retail cost and are seeking reimbursement. Submit this form with the original receipt(s)**., Cancelled checks, and credit card receipts are NOT acceptable as proof of purchase.** This will only delay payment as they do not contain the necessary information needed to process a claim.
Claims will be subject to limitations and other provision of the plan benefit.

Patient Information (one form per patient)			
Cardholder Name:	Cardholder DOB:	Cardholder ID #	Health Plan (Insurance) Name:
Mailing Address:	City:	State: Zip Code:	Primary Phone #: Secondary Phone #:
Member Name *(if other than cardholder)*	Member DOB:	Relationship to Cardholder: ☐ Self ☐ Spouse ☐ Child ☐ Other	Date of purchase: Pharmacy Name and Address:

REQUIREMENTS OF COVID HOME TEST REIMBURSEMENT

- Member must be eligible at time of purchase
- Maximum reimbursement is $12.00 per test
- Maximum number of tests is 8 per member per month, regardless of number of reimbursement requests
- ORIGINAL register receipt required, with purchase date, purchase item, store location, store address CLEARY NOTED ON RECEIPT. Copies of register receipt are not acceptable.
- Checks will be made out to Plan Cardholder if member is under the age of 18 years old
- Payments may take up to 90 days from date of processing reimbursement

I certify that the information on this claim form is correct and authorize release of all information to Ventegra. I also certify that the patient for whom this claim is made is eligible for benefits and does not have primary prescription drug coverage under any other group medical plan, i.e. workman's comp. I understand that drug(s) listed below is not for treatment of an on-the-job injury or covered by any other insurance plan.

Signature: **Date:**

Ventegra Customer Care Team: 877-867-0943
Open Monday – Friday: 5:00 AM/PST to 9:00 PM/PST
Saturday: 7:00 AM to 7:00 PM/PST, Sunday: 7:30 AM/PST to 4:00 PM/PST for your convenience

Reimbursements are based on the established network agreements with our preferred providers. This agreement, in part, states that you, as a member of Ventegra, Inc. will receive up to but no more than $12 per test kit purchased. Form and receipt must be mailed as original receipts need to be attached. Emailing or faxing completed DMR forms is not acceptable. Completed DMR form(s) received after the 25th of the month will be processed the following month. *Claims may take up to 90 days to process.*

Please verify that the Prescription receipt contains the following information about the prescription:

❑ Pharmacy Name:	❑ Patient Name:	❑ Amount Paid:
❑ Pharmacy Address:		❑ Date Of Service
❑ Pharmacy Phone Number:		❑ Quantity Dispensed

Please mail label receipts and this complete form to:
Ventegra, Inc.
10400 Overland Road
Box #353
Boise, ID 83709