VENTURA COUNTY
HEALTH CARE PLAN
A Department of Ventura County Health Care Agency

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 employee 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
Brown Mail: L#3670

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.

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1. Enrollee Information:

Name:_____ Date of Birth____/_____/_____
(First) (Middle) (Last)

Address:_____ City:_____ State:_____ Zip:_____

2. Employee (Subscriber) Information:

Name:_____ Mbr ID #:_____ Employee #:_____
(First) (Middle) (Last)

Home Phone:_____ Work Phone:_____ E-mail:_____

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

❑ At-Home COVID Test ❑ Other:_____

4. Purchase Information:

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

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 or service.

_____ _____
Employee Signature **Date**