OTC COVID-19 Test Claim Form

To be completed by cardholder/employee.
Please clearly PRINT all information

File a Claim by Mail:
Nova Healthcare Administrators
an Independent Health company
P. O. Box 211428, Eagan, MN 55121
Fax: (716) 932-5098

1	Group #:	Employer:		Policy Holder/Subscriber ID:	
2	Employee Status: ☐ Active	☐ Retired	☐ COBRA	☐ Terminated	
3	Name of Cardholder/Employee	☐ Married ☐ Single	☐ Male ☐ Female Birthdate:		Daytime Phone #:
4	Address of Cardholder/Employee: Number & Street		City	State	Zip
5	For dependent claims, complete lines 5, 6, 7	Name of Dependent: Birthdate:	☐ Married ☐ Single	☐ Male ☐ Female	Relationship:
6		Employer of Dependent *(if any)*:	Address of Employer:		
7		School where Dependent is enrolled:		Expected Date of Graduation:	

8	Are you or any of your family members covered under another group health plan or Medicare? ☐ Yes ☐ No	If yes, (a) Insurance Company: (b) Employer: (c) Policy # or ID #:
9	*Many test kits include two tests. Reimbursement applies to the number of tests, not the number of boxes.* Please indicate the number of tests included on this request for reimbursement. _____ Tests	

ATTESTATION: I attest that the Over-the-Counter (OTC) COVID-19 diagnostic test(s) for which I am requesting reimbursement had been purchased by my eligible dependent(s) or me under the plan, on or after January 15, 2022, and are for personal use, not employment purposes. I further attest that the OTC COVID-19 test(s) has not been and will not be reimbursed by another source and is not for resale. I understand reimbursement will be made in accordance with the guidelines set by the Departments of Labor, Health and Human Services, and the Treasury and the provisions of the plan. I accept all responsibility for the proper treatment of benefits under this plan with respect to eligibility, income tax reporting and liability.

I hereby certify that the above statements are complete and accurate to the best of my knowledge. I agree to reimburse the plan or its representatives to the extent of any overpayment in excess of the amounts payable under the plan.

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Cardholder/Employee Signature Date

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Nova Healthcare Administrators, Inc., Independent Health, or its authorized representatives, to obtain any information which may be necessary to determine benefits payable under the benefit plan administered by Nova Healthcare Administrators, Inc. A photocopy of this authorization will be valid.

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Patient's Signature *(or parent if the patient is a minor)* Date

Please complete this form and be sure to include an itemized receipt that includes both the purchase price and date of purchase.

Questions? Please call our Customer Service department using the number on your ID card.