Member Submitted Claim Form for At-Home, Self-Read COVID-19 Tests

Note: Incomplete claim forms will be returned and will delay the processing of the claim.

Member Instructions

1. Complete the fields below and sign form
2. Submit completed form along with any receipts, itemized statements and proof of payment by:
   - Fax: (701) 282-1888
   - Mail: CHAND
     Attn: Medical Claims Department
     4510 13th Ave S
     Fargo, ND 58121
3. Retain copies of all documents for your records

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Patient Information		
Patient's Name		
Address		
City	State	Zip Code
Phone Number	Date of Birth	
Gender ☐ Male ☐ Female	Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other	

Insured Information		
Insured's Name		
Insured's ID Number	Phone Number	
Address		
City	State	Zip Code

At-Home, Self-Read COVID-19 Test	
Below fields must be completed or form will be returned.	
Date of Purchase	Quantity of Individual Tests
Brand Name of Test	

UPC Code from Test: How will you be providing this?

☐ Fill in UPC Code ____

☐ Upload an image of UPC Code below ☐ Cut out UPC Code and mail with application

☐ By checking this box, I confirm the UPC Code from my At-Home, Self-Read COVID-19 Test will be provided with this application.

Patient's or Authorized Person's Signature	
I authorize the release of any medical or other information necessary to process this claim.	
By submitting a claim for reimbursement of an At-Home, Self-Read COVID-19 test, the member is attesting that it was purchased for personal use, not for employment purposes, and will not be reimbursed by another source or used for resale.	
Signature	Date