Request Repayment for At-Home COVID-19 Over-the-Counter (OTC) Tests

Use this form to ask us to pay you back for At-Home COVID-19 OTC Tests that you bought at a store or online. You may ask us to repay you for up to 2 individual FDA authorized tests (one week’s supply) on this form. Please fill in all blanks below and attach your receipts to support this request. You may send the form by mail, email or fax.

Mail:  
VNSNY CHOICE  
220 East 42nd Street, 3rd Floor  
New York, NY 10017  
Attn: Contact Center Shared Services

Email:  
RepayMe@vnsny.org

Fax:  
646-524-8338

Your Information

Member ID

Telephone Number

First Name

Last Name

Address

Apt #

City

State  
Zip

Purchase Information

Please check the box and include the number of individual FDA authorized test(s) you bought.

☐ ________ BinaxNOW COVID-19 Antigen Self-Test

☐ ________ CareStart COVID-19 Antigen Home Test

☐ ________ InteliSwab COVID-19 Rapid Test

☐ ________ QuickVue At-Home COVID-19 Test

☐ ________ Other ____________________________

COVID-19 tests eligible for repayment must be FDA authorized. List may change as new tests are approved.

To see if your test is covered and FDA authorized please visit: www.selecthealthny.org/covid19.

Purchase Date

Total Cost (Attach receipts)

Signature

Date