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

Select HEALTH VNSNY CHOICE

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.

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

- ☐ _____ BinaxNOW COVID-19 Antigen Self-Test
- ☐ _____ CareStart COVID-19 Antigen Home Test
- ☐ _____ InteliSwab COVID-19 Rapid Test
- ☐ _____ QuickVue At-Home COVID-19 Test
- ☐ _____ Other _____

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

Purchase Date _____

Total Cost (Attach receipts) _____

Signature _____

Date _____