Montana University System
Over-the Counter (OTC) COVID-19 Test Claim Form

MEDICAL PLAN ID# : ________________________________

POLICYHOLDER NAME : ____

PATIENT DATE OF BIRTH : _________________

ADDRESS : ____
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PATIENT NAME	PURCHASE DATE	PURCHASE AMOUNT

TOTAL AMOUNT: $________________

By signing, I am certifying that the above information is true and accurate and has not been submitted elsewhere for reimbursement.

____ ________________
Signature of person completing this form Date

Please attach a receipt for each OTC COVID-19 test kit purchased and submit with this form.

Remittance of this form is not a guarantee of payment. All claims are subject to review of the receipt(s) submitted and the patient must be covered on MUS *Choices* Medical Plan on the date of purchase.

Submit claim(s) and receipt(s) to: Traci Swingley, OCHE- MUS Benefits (tswingley@montana.edu, fax (406) 449-9157, or P.O. Box 203203, Helena, MT 59620).

Keep a copy of this completed form and the receipt(s) for your records.

Questions? Contact Traci Swingley at 406-449-9164 or tswingley@montana.edu.