CLAIMS SUBMISSION FOR
Over the Counter COVID-19 Tests

Send information to:

P.O. Box 1068
Decatur, Illinois 62525
800-798-2422 (toll free)
Fax form to: 217-423-4575 OR scan and email to customerservice@consociate.com

Insured/Employee Information

Insured/Employee Name: (First/Last)	Member ID and Employer Name:	Date of Birth:
Address: (Street, City, State, Zip)		

Claim Information

Please Note: In addition to completing the below claim information. All Reimbursements will require documentation showing proof of purchase to be attached. Documentation should contain the Merchant Name, Date of Purchase, Description of items purchased and total expense. Please attach copy of cash register receipt.

Member Name	Relationship to Insured	Month Purchased*	Merchant Name	# of tests purchased	Total Expense
				Total Expense Requested	
*COVID-19 Test Kits are limited to 8 test kits per month or 30 day period per person covered under the plan.					

I certify that the information submitted on this form and the documentation attached is correct and that the members indicated above are eligible for benefits under my employer's Group Health Plan.

Insured/Employee/Member or Legal Representative Signature **Date**