Reimbursement Claim Form for Over-the-Counter at-home COVID-19 Tests WITH a Healthcare Provider Order

Please use this form to request reimbursement for over-the-counter (OTC) at-home COVID-19 tests that have been purchased **when you have an order** from a healthcare provider. To qualify for reimbursement, the tests must be authorized by the Food and Drug Administration (FDA) for emergency use.

Important instructions

- **If you have no healthcare provider order for these tests, please use the claim form for OTC at-home tests WITHOUT a healthcare provider order.**
- This form is for OTC at-home COVID-19 tests purchased for you and other members on your plan. **This does not include swabs or tests that need to be sent to a laboratory for results.**
- Medi-Cal members **do not** use this form.
- All fields marked with an asterisk (*) are required.
- Submit a receipt or other proof of payment for test(s) purchased.
- Receipt(s) must clearly show date(s) of purchase and charges for the OTC at-home test(s).
- Each test is counted individually even if a package includes two (2) or more tests.
- Using black or blue ink, fill out the form below. You can also complete the form on a computer, then print out the completed form and mail it in.

Note: If you have primary medical coverage with another carrier, please submit your claim to that carrier first. Check with them on how to file your claim.

Please remember to sign your name in the space provided. Mail the completed form and proof of payment to the address listed at the bottom of this form. Your reimbursement may be delayed or denied if we do not receive the required information.

Subscriber information

*Full name:		
*Subscriber ID:	Group #:	
Address:		
City:	State:	ZIP code:
Email address:	Phone #:	

OTC at-home tests purchased for subscriber and members

List the subscriber/members for whom tests were purchased. **Each test should be counted separately.** This applies even if a package includes two (2) or more tests.

	*Full name (first, middle, last)	*Date of birth	*Number of OTC at-home tests ordered by healthcare provider
1			
2			
3			
4			
5			
	Total number of OTC at-home tests submitted for reimbursement on this form		
	***Grand total purchase price for all receipts of OTC at-home tests for this claim**		*$

Note: This table can fit up to five (5) members. If you need to include additional members, please include a separate sheet with the required information with this claim form.

*Provide the name(s) of the FDA-authorized OTC at-home test(s) purchased. For example, BinaxNOW, iHealth, CareStart, Intelliswab:

Healthcare provider information

For each member listed in the table above, add the information for the healthcare provider who ordered their test(s) below. List in the same order as in the previous table.

	*Member's first name	*Name of their provider	*Provider address	*City	State	ZIP	Provider phone #
1							
2							
3							
4							
5							

Note: If you need to identify additional providers, please include a separate sheet with the required information with this claim form.

Member signature

By submitting this form, I certify that the information I provided is correct and I authorize the release of any medical information necessary to process this claim. I further attest that I am requesting reimbursement for OTC at-home COVID-19 test(s) purchased with a healthcare provider order.

Signature	**Date**

Form continues on Page 3

Mail completed form with copy of purchase receipt(s) to:

Blue Shield of California
P.O. Box 272540
Chico, CA 95927-2540

Questions?

If you have any questions, please contact customer service at the number on your Blue Shield member ID card.