Reimbursement Claim Form for Over-the-Counter at-home COVID-19 Test WITHOUT 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 **without** a healthcare provider order. To qualify for reimbursement, the tests must be authorized by the Food and Drug Administration (FDA) for emergency use.

Important instructions

- **If you have an order for these tests from a licensed, authorized healthcare provider, please use the claim form for OTC at-home tests WITH a healthcare provider order.**
- Medi-Cal and Medicare Advantage members do not use this form.
- 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.**
- 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.
- All fields 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.
- Each member on your plan can request reimbursement for up to eight (8) tests per month without a healthcare provider order.

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 at-home tests purchased for this member	Number of at-home tests purchased at your employer's direction (employment screening for return to work)
1				
2				
3				
4				
5				
6				
7				
8				
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 eight (8) 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:

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 for **personal use and not for resale, and I have not and will not be reimbursed by another source.**

Signature	**Date**

Please 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 phone number on your Blue Shield member ID card.