COVID-19 OVER-THE-COUNTER (OTC) TESTING

MEMBER REIMBURSEMENT FORM

Non-Medicare Advantage

Please use this form to request reimbursement for COVID-19 tests you have paid for out of your own pocket. To be eligible for reimbursement, the following must apply:

- The test was self-administered and self-read at home and did not involve a healthcare provider.
- Tests must be authorized, cleared or approved by the FDA. For a list of EUA authorized tests, go **here** and enter OTC into the list search box located under the article titled *Individual EUAs for Antigen Diagnostic Tests for SARS-CoV-2* and above the table. Please note, tests must be self-administered and self-read. Any test that requires a healthcare provider to administer or read is not eligible. The list may be subject to change.
- You must provide a copy of the receipt and the UPC code (cut from the test box).
- Reimbursement is limited to 8 tests per covered individual per month. Please submit a separate form for each covered individual seeking reimbursement.
- Sales tax and delivery charges will not be reimbursed.

Reimbursement will not be approved without all the documentation listed above. All fields below must be completed to enable processing of your request.

MEMBER INFORMATION

You can find your member ID and group number on your member ID card.

Member ID (Include 3-Digit Alpha Prefix)	Group Number	Date of Birth
Member's Last Name	Member's First Name	
Member's Street Address		
City	State	Zip Code

PLEASE PROVIDE THE FOLLOWING INFORMATION FOR THE OVER-THE-COUNTER TEST KIT(S) YOU PURCHASED:

Manufacturer of the test (FDA-approved list): ______________________________

Where was test purchased (for example, CVS, Walgreens, Amazon.com)? ______________________________

Number of tests per kit: __________ Date of purchase (MM/DD/YYYY):__________________ Total cost: $ ________________

By signing below, I am stating that the information above is correct. Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information, may be guilty of a criminal act punishable under law and may be subject to civil penalties. In addition, I attest that any claims for reimbursement for over-the-counter COVID-19 antigen tests will be used for the patient named above for personal use and is not for employment purposes, has not been (and will not be) reimbursed by another source, and is not for resale.

Signature	Date	Phone Number

We value your privacy. We won't release any information about you unless you ask us to in writing or we must do so to process or review your claim (by sharing with another insurance company, for example). We'll tell you which information we released and to whom, if you request it.

PLEASE MAKE SURE YOU PROVIDE THE FOLLOWING DOCUMENTS WITH THIS FORM:

- For at-home tests you must provide a copy of the receipt and the UPC code (cut from the test box).
- Keep copies of your original receipts for your files. We can't return originals to you.

MAIL THIS FORM TO:
Blue Cross and Blue Shield of Kansas City
ATTN: COVID OTC Tests
P.O. Box 419169
Kansas City, MO 64141-6169

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