1110 Main Street
Wheeling, WV 26003-2704
P: 1.800.624.6961
healthplan.org

Member Submitted Claim Form – COVID At-Home Test Kits

This form is to be used for COVID at home test kits where you incurred expenses from a provider/retailer.

See instructions on other side for additional information to complete your claim.

Section 1: Patient/Member			
ID number/suffix	Group number	Patient name (first, middle, last)	
Address	City	State	ZIP code
Home phone	Work or alternate phone	Employee name	Email address

Does the patient have coverage from any other health plan?

☐ No, skip to Section 2

☐ Yes, please attach the explanation of benefits (EOB) statement from the primary plan with this claim and complete following information:

Name of other health plan	ID number or policy number of other health plan	Phone number of other health plan

Section 2: Claim Details
NOTE: You must submit an itemized bill or your claim will be returned.

Have the charges been paid in full? ☐ No ☐ Yes, please attach proof of payment in full.

Total number of kits requested for member _____. Total cost for member _____.

Have you received COVID tests reimbursement in the past? If so, indicate which family member/self. ☐ No ☐ Yes _____

Is this reimbursement request for at-home COVID tests a work requirement? ☐ No ☐ Yes

Section 3: Signature

By submitting this form, I attest that the COVID-19 test was purchased for personal use and will not be reimbursed by another source or used for resale.

To be accepted, this form must be fully completed (as appropriate to the claim being submitted), signed and have and itemized bill attached.

Mail to: The Health Plan, 1110 Main Street, Wheeling, WV 26003-2704

Fax to: 740-699-6163

Patient signature (or legal guardian if patient cannot legally consent to services)	Relationship to patient ☐ Self ☐ Other	Date (mm/dd/yyyy)

Please note: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

** Certain rules apply. Be sure to keep a copy of the itemized receipt from your purchase. You must submit the receipt along with a completed reimbursement form. Your ID card contains information you will need to complete the reimbursement form, such as your ID number and suffix. In signing the form, you attest that the test (a) is for personal use; (b) will not be reimbursed by another source; and (c) is not for resale. Tests required to satisfy an employment purpose will not be reimbursed.*

Up to 8 FDA approved tests per enrolled member per month can be reimbursed. Please note that this requirement applies to the number of tests, not the number of kits or the number of purchases. For instance, if you buy 4 kits and each kit contains 2 tests, you have reached the limit of 8 tests for the month.

The requirement that health insurance issuers must reimburse for the cost of at-home COVID-19 test kits applies only during the public health emergency. You do not need to be seen by a doctor, nor to have a prescription from your health care provider, in order to purchase an over-the-counter COVID-19 test.

Instructions

Complete a claim form.

- Include the date of service and a copy of the itemized charge or receipt for each service rendered.
- **Please note:** Your claim will be returned if all of the required information listed above is not included.

The front of your member ID card may not match the card pictured below. This sample card is meant to be a guide to help you identify your suffix and identification number.