Blue Cross of Idaho Rx

Over-the-counter, at-home COVID-19 Test Reimbursement Claim Form

Important!

- **If you are submitting for over-the-counter, at-home COVID-19 test reimbursement, you need to complete and sign the claim form. Do not submit for at-home COVID-19 test reimbursement without signing the claim form or your submission will be rejected.**
- **Keep a copy of all documents submitted for your records.**
- **Do not staple receipts or attachments to this form.**
- **Reimbursement is not guaranteed. Claims are subject to limitations, exclusions and provisons of the plan.**
- **Do not use this claim form to request reimbursement for other prescription drug claims.**

STEP 1 Card Holder/Patient Information

This section must be fully completed to ensure proper reimbursement of your claim.

Card Holder Information

Identification Number (refer to your ID card)

Group Number/Group Name

Last Name

First Name

MI

Address

Address 2

City

State

ZIP/Postal Code

Country

Patient Information–Use a separate claim form for each patient

Last Name

First Name

MI

Date of Birth

Phone Number

Relationship to Primary Member

Member ○ Spouse ○ Child ○ Other ○

Retailer Information

Retailer Name

continued

Important! A signature is REQUIRED

NOTICE

I certify that the over-the counter, at-home COVID-19 tests were purchased for personal diagnostic use, and not for purposes of employment, have not been and will not be reimbursed by another source, and are not for resale. The over-the-counter, at-home COVID-19 tests were purchased only for the Health Plan-covered members in my own household.

I have read and understood this form and certify that all information entered on this form is true and correct.

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties, including fines, denial of benefits and/or imprisonment.

x _____

Signature of card holder (REQUIRED) **Date**

STEP 2 Submission Requirements

You MUST include all original pharmacy or cash register receipts or on-line proof of purchase in order for your claim to process. The minimum information that must be included on your pharmacy or cash register receipts or on-line proof of purchase is listed below:

- Date of Purchase
- Price of Purchase
- Name of over-the-counter, at-home COVID-19 Test

Name of over-the-counter, at-home COVID-19 Test: _____

Number of over-the-counter, at-home COVID-19 Tests you are submitting for reimbursement (For example: If you buy a multi-pack of tests, each test in the package counts as a single test. So a four-pack counts against the limit as four tests.): _____

Additional comments:

STEP 3 Mail completed forms with receipts to:

Claims Department
P.O. Box 53993
Phoenix, AZ 85072-3993

CLEAR FORM