

COVID-19 At-Home Test Member Reimbursement Form



Please use this form to request reimbursement for actual cost of FDA-approved COVID-19 at-home test(s).

To be eligible for reimbursement, you must submit:

- A separate Member Reimbursement Form for each member for whom the at-home test is purchased.
- Original receipt (not a photocopy) for at-home test(s), showing the amount paid and the test(s) purchased.
- Actual UPC/barcode from packaging of the at-home test(s).

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

Policyholder information. You can find this information on your plan ID card.

Group Number	Policyholder's ID		
Policyholder's last name		Policyholder's first name	
Policyholder's street address			
City	State	ZIP code	

Patient information (Who the test is for)

Last name	First name	Date of birth
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Reason for the test

- I was exposed to someone with COVID-19.
 I had COVID-19 symptoms.
- Required for employment purposes
- Other: _____

Test information

Manufacturer of the test: _____

Where was the test purchased (for example, Pharmacy)? _____

Purchase date: _____ Number of tests: _____ Cost of test(s): \$ _____

Submitting Your Claim for Reimbursement

Here are the steps for submitting your claim for reimbursement:

- If multiple tests are on the same receipt and are being used by different covered members, complete and include one Member Reimbursement Form for each member.
- Attach the original receipt for the test(s) (not a photocopy). If you ordered the test online, please print and attach your electronic receipt. **Please be sure to keep a copy of your original receipt.**
- Remove the UPC/barcode from the packaging of the at-home test.
- Place Member Reimbursement Form(s), original receipt and UPC/barcode(s) in an envelope and mail to the address below.

I certify the information is true for the expenses incurred by the patient listed above, and the enclosed material is correct and unaltered. False receipts or altering of this information will result in civil or criminal prosecution. I attest that this is not for employment purposes. I attest that this has not or will not be reimbursed by another source. I attest that this is not being purchased for resale.

Signature	Date	Phone number

Mail Reimbursement Request to:

PAI

COVID Member Reimbursement

P.O. Box 6927

Columbia, SC 29260