# MEMBER REIMBURSEMENT MEDICAL CLAIM FORM – AT-HOME COVID-19 TESTS

(**For at-home COVID-19 tests purchased through a retail vendor outside of the pharmacy counter**- please complete one form per family member)

## Instructions

1. To request reimbursement for COVID-19 at-home test kits not purchased through your Pharmacy, please submit the following to the address listed at the bottom of this form within one year from purchase date † (any missing information may result in delay or denial of the request):
   a. This completed and signed reimbursement form b. Proof of payment for requested for reimbursement c. Include itemized list of services or retail items for reimbursement review.
2. Most completed reimbursement requests are processed within 30 days. Incomplete requests will be rejected, and requests for testing services that were rendered outside of the United States will not be reimbursable under this benefit.
3. Reimbursement will be sent to the Plan subscriber (see Help Sheet for definition) at the address Ambetter from MHS has on record (To view your address of record, please log on to Ambetter.mhsindiana.com or call Member Services at 1-877-687-1182 (TTY/TDD 1-800-743-3333)).
4. Retain a copy of all receipts and documentation for your records.

## Subscriber Information

| Last Name: | First Name: | Middle Initial: |
|---|---|---|
| | | |

## Patient information

| Patient's Member ID#: | Last Name: | First Name: | Middle Initial: |
|---|---|---|---|
| | | | |

| Date of Birth (MM/DD/YYYY): | Mailing Address: |
|---|---|
| | |

| Telephone Number: | Patient Email Address: | Does Patient have additional insurance? ☐Yes ☐No | Did other Insurance make a payment: ☐Yes ☐No **(If yes, include plan's EOB)** |
|---|---|---|---|
| | | | |

| Other Insurance Company Name: | Other Insurance Company Phone Number: | Other Insurance Policy Number: |
|---|---|---|
| | | |

| Purchased Date† | Diagnosis Code | Procedure Code | Modifier | Retail Provider* (e.g., retail counter, grocery store, Amazon, etc.) | Quantity* (Number of tests purchased) | Amount Paid |
|---|---|---|---|---|---|---|
| / / | Z20.822 | E1399 | CS | | | $ |
| / / | Z20.822 | E1399 | CS | | | $ |
| / / | Z20.822 | E1399 | CS | | | $ |
| / / | Z20.822 | E1399 | CS | | | $ |
| | | | | | | $ |

* For over-the-counter (OTC) at-home COVID-19 tests that are sold from a location outside of Ambetter's in-network pharmacies (e.g., Amazon, grocery store, etc.) in packages that contain more than one test will be limited to a reimbursement amount of $12, or the cost of the test if less than $12, per test per covered individual pursuant to Federal guidance. Maximum reimbursement for at-home COIVD tests is limited to 8 test per member or dependent every 30 days.

† This form must be completed and submitted within one year from purchase date. The one-year requirement will be waived if you or your covered dependent had no legal capacity to submit such proof during that year.

**Ambetter Member signature is required** **Total Amount Paid**

Ambetter from MHS complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Ambetter from MHS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

I attest that the above information is true and accurate and that the services were received and paid for in the amount requested as indicated above. I acknowledge that if any information on this form is misleading or fraudulent my coverage may be cancelled, and I may be subject to criminal and/or civil penalties for false health care claims. I understand that reimbursement payment will be made to the Plan subscriber and will contain information about the service (e.g., provider name, date, description of service).
I also understand that Ambetter from MHS may request any additional information it deems necessary to verify that services were received, and payment was made.

Printed Name _____ Signature _____ Date _____

## Checklist

1. I have completed and signed this form in its entirety.
2. I have enclosed documents of Proof of Services received (see the help sheet for an example of proof of payment).
3. I have enclosed documents of Payment of Services – not related to copay or plan deductible (see the help sheet for an example of proof of payment).
4. I understand that most completed reimbursement requests are processed within 45 days. Incomplete requests and requests for services rendered outside of the United States will not be reimbursable.

**Please submit this form and all documentation to:**
Ambetter from MHS • Attn: Claims Department-Member Reimbursement • P.O. Box 5010 • Farmington, MO 63640-5010

# MEMBER REIMBURSEMENT MEDICAL CLAIM FORM – AT-HOME COVID-19 TESTS

# HELP SHEET / FAQs

| Question | Answer |
|---|---|
| What is this form used for? | This form is used to request payment for eligible at-home COVID-19 tests that are sold from a location outside of Ambetter's in-network pharmacies (e.g., Amazon, grocery store, etc.). |
| If my at-home COVID-19 test kit has multiple tests in the box, how will I be reimbursed? | For over-the-counter (OTC) at-home COVID-19 tests in packages that contain more than one test will be limited to a reimbursement amount of $12, or the cost of the test if less than $12, per test per covered individual pursuant to Federal guidance. |
| How many individual tests can I buy and submit for reimbursement? | Maximum reimbursement for at-home COVID-19 tests are limited to 8 tests per member or dependent every 30 days. |
| How long do I have to submit my request for reimbursement? | This form must be completed and submitted within one year from the purchase date. The one-year requirement will be waived if you or your covered dependent had no legal capacity to submit such proof during that year. |
| What if I purchased at-home COVID test(s) prior to the January 15th, 2022 Federal Rule change? | Tests purchased prior to the January 15th, 2022 Federal Rule change will not be eligible for medical reimbursement. |
| Who should I contact if I need help with completing this form? | Contact Member Services at 1-877-687-1182 (TTY/TDD 1-800-743-3333). |
| **Field Name** | **Description** |
| Subscriber Information | Subscriber is the person:<br>Who enrolls in a Ambetter from MHS and signs the membership application form on behalf of him/ herself and any dependents in whose name the premium is paid. |
| Patient's Member ID# | ID# with suffix, found on the front of the Ambetter from MHS Member ID card. |
| Patient's Name | Last and First names and Middle Initial of patient who received services. |
| Patient's Date of Birth | Date of birth: month (2 digits), day (2 digits), year (4 digits). Include newborn's date of birth in the same box as the parent's. |
| Retail Provider | Include retail provider where at-home COVID-19 test was purchased. This form is used when at-home tests are purchased from a location outside of Ambetter's in-network pharmacies (e.g., Amazon, grocery store, etc.). |
| Date(s) Purchased | The date(s) the at-home COVID-19 tests were purchased. |
| Quantity | Include the total number of individual at-home COVID-19 tests purchased. For over-the-counter (OTC) at-home COVID-19 tests in packages that contain more than one test, include the total number within the test kit. Reimbursement will be limited to a reimbursement amount of $12, or the cost of the test if less than $12, per test per covered individual pursuant to Federal guidance. |
| Total Amount Paid | Total amount for which you are requesting reimbursement. For over-the-counter (OTC) at-home COVID-19 tests in packages that contain more than one test will be limited to a reimbursement amount of $12, or the cost of the test if less than $12, per test per covered individual pursuant to Federal guidance. |
| Proof of Payment | A document that demonstrates payment made by the member was received by the provider of service. Examples include: The front and back of the cancelled check written to the provider or the bank encoded front of the check written to the provider; a credit card statement or receipt; a statement from the provider, on the provider's letterhead with authorized signature, indicating payment was made; a receipt for purchased items, with the provider's name and address preprinted on the receipt, with items listed and amount paid. |

**Please submit this form and all documentation to:**

Ambetter from MHS • Attn: Claims Department-Member Reimbursement • P.O. Box 5010 • Farmington, MO 63640-5010