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 on or after Jan. 15, 2022.
- Original receipt(s) (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 BlueChoice HealthPlan of South Carolina ID card.

Alpha prefix	Policyholder's ID
Policyholder's last name	Policyholder's first name

Policyholder's street address

City	State	ZIP code

Patient information (Who is the test for?)

Last name	First name	Date of birth

Reason for test

☐ I was exposed to someone with COVID-19.

☐ I had COVID-19 symptoms.

☐ It is required for employment purposes.

☐ Other: _____

Test information

Manufacturer of the test: _____

Where was the test purchased (for example, pharmacy or store)?: _____

Purchase date: _____

Number of tests*: _____ Cost of test(s): _____

** Please provide the total number of individual tests shown on the receipt(s) you have included with this form that will be used by this patient. If you purchased a kit with multiple individual tests, include only the number of tests from the kit that will be used by this patient.*

BlueChoice® HealthPlan
South Carolina

Submitting your claim 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(s) for the test(s) (not a photocopy). If you ordered the test online, please print and attach your electronic receipt(s). Please be sure to keep a copy of your original receipt(s).
- Remove the UPC/barcode from the packaging of the at-home test.
- Place Member Reimbursement Form(s), original receipt(s) 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 may result in civil or criminal prosecution, and/or termination of my coverage. 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	Print name

Date: _____ Phone number: _____

Mail reimbursement request to:

BlueChoice HealthPlan
COVID Member Reimbursement
PO Box 6170
Columbia SC 29260-6170