Harvard Pilgrim Health Care

Member Reimbursement Form

COVID-19 At-home Test

Please complete this form to be reimbursed for over-the-counter COVID-19 at-home tests. Only at-home tests that have an Emergency Use Authorization (EUA) from the FDA are eligible for reimbursement.
Check the FDA-authorized list or our FDA/EUA authorized chart on our website.

Get started now

1 Complete one form per family member per claim.

2 For individualized diagnosis or treatment of COVID-19 (not for resale), and not for employment purposes. Reimbursement is permitted for up to eight over-the-counter COVID-19 at-home tests per member per month.

3 Submit the following to the address listed at the end of this form (any missing information may result in delay or denial of the reimbursement):
- **a.** This completed and signed reimbursement form
- **b.** Proof of payment for the COVID-19 at-home tests being requested for reimbursement

Reimbursement will be sent to the Plan subscriber at the address the Plan has on record. To view your address of record, please log on to www.harvardpilgrim.org or call Member Services at the number listed on the back of your ID card.

4 Cost of shipping and handling and tax are not included.

Reminder: Items purchased through a flexible spending account (FSA) are not reimbursable.

Subscriber (policy holder) information

Reimbursement will be sent to the person listed below.

*Last name	*First name	Middle initial

*Street address

*Town/City	*State	*ZIP code

**Required fields*

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Member information

By providing your contact information below, you agree to be contacted by us via email and/or phone regarding your plan benefits and administration.

*Last name	*First name	Middle initial

*Member's health plan ID #	*Date of birth (MM/DD/YYYY)

Email address	Mobile phone number	Home phone number

At-home test purchase information

Please note that some test kits may contain multiple tests in a box. Please indicate how many tests are per box below.

*Brand name of at-home test (e.g., iHealth, BinaxNow, etc.)	*Test name (e.g., antigen self test)	*Number of tests per box	*Date(s) of purchase (MM/DD/YY)	*Amount paid
				$
				$
				$
				$
				$
				$
				$
				$
			Total	$

*Required fields

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Member signature (required)

I attest that the above information is true and accurate and that the over-the-counter at-home COVID-19 tests submitted for reimbursement were purchased by me from an originating seller in the amount requested as indicated above. I further attest that these at-home tests are for personal use, intended for individualized diagnosis or treatment of COVID-19 (not for resale), and are not for employment purposes. I further attest that these tests have not been and will not be reimbursed by another source.

I acknowledge that if any information on this form is misleading or fraudulent, my coverage may be canceled 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 Harvard Pilgrim Health Care may request any additional information it deems necessary to verify that the tests were received for the covered purpose and payment was made.

*Signature	*Date (MM/DD/YY)

Let’s double check

- I have completed and signed this form in its entirety.
- I have enclosed proof of payment.
- I understand that most completed reimbursement requests are processed within 30 days.
- I have kept copies of my original receipts for my records.

Mail this form and proof of payment to:

Harvard Pilgrim Health Care
Member Reimbursement Claims
1 Wellness Way
Canton, MA 02021

For internal use only
Procedure code: 87811
Diagnosis code: Z11.52
Modifier: 32

**Required fields*