At-home Over-the-counter (OTC) COVID Test Reimbursement Form

For use with the Humana Family of Health Insurance and Health Plan Companies

INSTRUCTIONS

1. Do **not** use for Medicare Advantage or Medicaid plans. (For Medicare Advantage or Medicaid plans, use standard claim form.)
2. Do **not** use for any test if a licensed healthcare provider provided a formal order for that purchased test. (If the test was ordered, use standard claim form.)
3. Use **only** to request reimbursement for self-administered, **at-home OTC COVID-19 diagnostic test(s) authorized by the U.S. Food and Drug Administration (FDA).** (For all other services, use standard form.)
4. Provide **all** information requested below. **Failure to provide all requested information or to sign the attestation below could result in denial of reimbursement.**
5. If tests were purchased for multiple individuals, use a separate form for the tests purchased for each individual.
6. Mail completed form to the address on the back of your insurance card.
7. Include, with the completed form that you mail, a **copy of the purchase receipt (required)** for the test(s) and a **copy of the UPC from the test package(s)**. If the receipt copy includes other items purchased at the same time, please clearly identify (carefully underline or place a star next to) the OTC COVID test(s) for which you're requesting reimbursement.

Employee/Member Name (Last) (First) (M.I.)	Employee/Member Birth Date (mm/dd/yy) / /	Member ID (11 characters)
Employee/Member Home Address	Phone Number ( ) -	Group Number
	Group Name	
Patient's Name (Last) (First) (M.I.)	Patient Birth Date (mm/dd/yy) / /	Patient's Relationship to Employee

INFORMATION FROM PACKAGE

	POS	HCPCS	Diagnosis code	Name of test brand (from package)	Number of tests per package (this brand)	Number of packages purchased (this brand)	Total amount paid for the test(s) (this brand)	Date purchased (mm/dd/yy)
1st Test Brand	99	U0002	Z20.822				$.	/ /
2nd Test Brand	99	U0002	Z20.822				$.	/ /

CERTIFICATION

I hereby certify that the over-the-counter (OTC) diagnostic COVID-19 test(s) purchased and for which I am submitting a request for reimbursement are for personal use only and are not for resale or for other individuals, other than me or my dependents in the health plan, to use. I also certify that the test(s) are not for employment screening or public health surveillance purposes and have not been (and will not be) reimbursed by another source. I understand that any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

Employee's/Member's or Authorized Person's Signature	Date

RELEASE OF INFORMATION

I authorize the release of any medical information necessary to process this claim. I understand that, as permitted by law, to the extent of benefits paid under this claim, the Plan acquires all rights of recovery I may have against other parties considered responsible for these expenses.

Employee's/Member's or Authorized Person's Signature	Date