SHARP HEALTH PLAN

Member reimbursement request form

At-home over-the-counter COVID-19 tests

Purpose

The purpose of this form is to ask for a refund from Sharp Health Plan for the cost of FDA approved at-home over-the-counter (OTC) COVID-19 tests.

Instructions

1. Reimbursement for approved charges will be mailed within 30 days of receipt of complete documentation.
2. Complete a separate form for each member who is requesting reimbursement. Only one form is needed per member.
3. The member who received the medical services must sign this form. If the member is under 18 years old, the form must be signed by the parent or guardian.
4. Send this completed form and the following documents to Sharp Health Plan. Incomplete forms and missing information may result in a delay or non-payment of your request. Please keep copies of all items sent to Sharp Health Plan, including the following:
   - Proof of payment in the form of an itemized receipt.
   - The brand name of the at-home OTC COVID-19 test that you purchased.
   - The Universal Product Code (UPC) from the box. The UPC code will be underneath the bar code and is typically a 12-digit number.
   - If you are requesting a reimbursement for more than 8 at-home tests, you will need to submit a physicians order proving that they were medically necessary.

Submit

Please submit the finished form and required documents by mail, in person, or fax:

By Mail or In Person*:
Attention: Claims Research
Sharp Health Plan
8520 Tech Way, Suite 200
San Diego, CA 92123

By Fax:
Attention: Claims Research
1-858-636-2276

*Pending safety guidelines

Member Information (Complete this section for all reimbursement requests.)		
First name:	Last name:	Middle initial:
ID#:	Phone number: ( )	Birth date (MM/DD/YY): / /
Home address (NOTE: P.O. box is not allowed.):		
City:	State:	ZIP code:
Please include the brand name of the at-home OTC COVID-19 test that you purchased, and the Universal Product Code (UPC) from the box. The UPC will be underneath the barcode and is typically a 12-digit number.		
Was test purchased as a result of an exposure at work? ☐ Yes ☐ No	If yes, give the date of the incident:	
Parent/Guardian enrolled in Sharp Health Plan (Complete this section if the member is under 18.)		
First name:	Last name:	Middle initial:
ID#:	Phone number: ( )	Birth date (MM/DD/YY): / /
Home address (P.O. box is not allowed):		
City:	State:	ZIP code:

Other Health Coverage (Complete this section if you have other health coverage.)		
Other health plan name:	Health plan phone number: ( )	Effective date of other coverage (MM/DD/YY):
Policy holder's name:	Policy holder's ID#:	Policy holder's birth date (MM/DD/YY):

Type of coverage: ☐ Medical ☐ Dental ☐ Vision ☐ Other	Type of policy: ☐ Self only ☐ Self and spouse ☐ Family ☐ Other

Certification Statement

I certify that the above information is true and the attached material is correct and unaltered and that the expenses were incurred by the patient named above. I understand all documents submitted become the property of Sharp Health Plan and will not be returned. I understand that if I submit false receipts or fraudulently altered documents, I may be disenrolled from Sharp Health Plan and/or subject to civil or criminal penalties. I authorize the release of any information needed to review or process this request.

A plan or issuer may take reasonable steps to ensure that an OTC COVID-19 test for which a covered individual seeks coverage under the plan or coverage was purchased for the individual's own personal use (or use by another participant, beneficiary, or enrollee who is covered under the plan or coverage as a member of the individual's family), provided that such steps do not create significant barriers for participants, beneficiaries, and enrollees to obtain these tests. For example, a plan or issuer could require an attestation, such as a signature on a brief attestation document, that the OTC COVID-19 test was purchased by the participant, beneficiary, or enrollee for personal use, not for employment purposes, has not been (and will not be) reimbursed by another source, and is not for resale. In contrast, the Departments are of the view that fraud and abuse programs that require an individual to submit multiple documents or involve numerous steps that unduly delay a participant's, beneficiary's, or enrollee's access to, or reimbursement for, OTC COVID-19 tests are not reasonable.

A plan or issuer may require reasonable documentation of proof of purchase with a claim for reimbursement for the cost of an OTC COVID-19 test. Examples of such documentation could include the UPC code for the OTC COVID-19 test to verify that the item is one for which coverage is required under section 6001 of FFCRA, and/or a receipt from the seller of the test, documenting the date of purchase and the price of the OTC COVID-19 test.

Member's name (Parent/Guardian if child):	Member's signature (Parent/Guardian if child):	Date (MM/DD/YY): / /

If you need assistance, we're here to help. You can call Customer Care at 1-858-499-8300 or toll-free at 1-800-359-2002, or email us at **customer.service@sharp.com.** We are available to assist you Monday through Friday, 8 a.m. to 6 p.m.

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call Sharp Health Plan right away at 1-858-499-8300 or 1-800-359-2002.

IMPORTANTE: ¿Puede leer esta carta? Si no le es posible, podemos ofrecerle ayuda para que alguien se la lea. Además, usted también puede obtener esta carta en su idioma. Para ayuda gratuita, por favor llame a Sharp Health Plan inmediatamente al 1-858-499-8300 o 1-800-359-2002.