COVID-19 AT-HOME TEST REIMBURSEMENT FORM

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

Instructions: Please use this form to request reimbursement for over the counter COVID-19 at-home tests you have paid for out of pocket. The test you received must be approved by the Food and Drug Administration. Check the FDA OTC Approved list. To be eligible for reimbursement you must submit the following:

- A separate form for each member for whom the at-home test is purchased.
- Original receipt(s) showing the amount paid and the test(s) purchased. Photocopies will not be accepted.
- Cut out and attach the UPC barcode label from each test(s). The UPC is the barcode scanned at checkout.

Mail your completed form and documentation to BCBSAZ, P.O. Box 13466 – Mail Stop A115, Phoenix, AZ 85002-3466.

You will be reimbursed via check, mailed to the address we have on file within 30 days of Blue Cross® Blue Shield® of Arizona (BCBSAZ) receiving your reimbursement information.

SECTION 1 – CARDHOLDER INFORMATION

Cardholder's ID Number	Group/Employer or Plan Name	Group No. (If applicable)

Cardholder's Name (Last, First, Middle Initial)	Date of Birth (mm/dd/yyyy)	Cardholder's Phone Number
	/ /	

Cardholder's Address (Street, City, State, Zip)

SECTION 2 – PATIENT INFORMATION

Reason for the test

I was exposed to someone with COVID-19. I had COVID-19 symptoms. Required for employment purposes.

Other:_____

Test Information

Where was the test purchased (for example Pharmacy)?_____

Purchase date:_____ Number of tests:_____ Cost of test(s):_____

Patient's Name (Last, First, Middle Initial)	Date of Birth (mm/dd/yyyy)
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SECTION 3 – CLAIM INFORMATION

1.	Date Purchased	Number of Tests Purchased	Pharmacy Name or Supplier Name	Claim Amount $
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COVID-19 At-Home Test Name

(Internal use only: DX Z11.52 CPT 87811 Tax ID 864570101 Provider P2001351)

I certify the information is true and the expenses incurred were for personal COVID-19 diagnostic test(s) obtained for the use of the member(s) listed above, and the enclosed material is correct and unaltered. False receipts or altering of this information may result in civil or criminal prosecution. I attest that the test(s) is not for employment purposes, resale, or any purpose other than the personal diagnostic use of the member(s) identified on this form and that the test(s) will not be reimbursed by another source.

SECTION 4 – ATTESTATION CERTIFIES THAT THE INFORMATION PROVIDED ABOVE IS TRUE, ACCURATE, AND COMPLETE.

Member's Signature	Today's Date (mm/dd/yyyy)
	/ /

Questions? Call the number on the back of your insurance card.

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