OTC COVID Test Member Reimbursement Claim Form

Instructions

Within this form, the terms "you" and "your" refer to the member. The terms "we", "our", and "us" refer to Healthcare Management Administrators (HMA), your third-party Health Plan administrator.

Use this form to submit claims for FDA-approved or FDA emergency use authorized (EU) PCR or antigen over-the-counter (OTC) COVID-19 tests[1] purchased by you or an enrolled dependent for your own use and that you're seeking reimbursement for under your Health Plan. Don't use this form for any other claim submission needs.

Please include itemized receipt(s) with your completed claim form. Each receipt must include the following, at minimum:

- Names of each person who will be using the COVID tests
- Date(s) of purchase
- Total number of tests purchased
- Total charge for each OTC COVID test kit

Note: If your Health Plan offers OTC coverage for COVID tests under your pharmacy benefits, your reimbursement under your medical benefits may be limited in accordance with federal guidelines and you may not receive full reimbursement for what you paid.

Any questions? We're here to help! Contact Customer Care at 800-869-7093.

Submission Information

Please provide the information in this form to us using one of the methods below (pick any option that works for you)**:**

Electronic Submission Options

✓ **DocuSign**:

1. Go to https://www.accesshma.com/news-and-resources/member-forms
2. Click on the DocuSign option under **OTC COVID Test Member Reimbursement Claim Form**
3. Fill out and submit the form in DocuSign

Paper Submission Options

✓ **Option 1: Fax** the completed form to: 425-285-3544

✓ **Option 2: Mail** the completed form to:
HMA
Attn: Claims Department
PO Box 85008
Bellevue, WA 98015-5008

Member Information

First Name _____ **Last Name** _____

Mailing Address[2] _____

City _____ **State** Select... **ZIP Code** _____

Phone Number _____ **Member ID Number**[?] _____ **Date of Birth** _____

Group/Employer Name _____ **Group Number**[?] _____

Member's Relationship to Policyholder ◯ Self ◯ Spouse ◯ Dependent

[?] *This information is on your insurance ID card. "Member ID" is also called "Employee ID".*

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1 A list of tests can be found at https://www.fda.gov/medical-devices/coronavirus-disease-2019-covid-19-emergency-use-authorizations-medical-devices/in-vitro-diagnostics-euas-antigen-diagnostic-tests-sars-cov-2

2 If your mailing address has changed, notify your Human Resources (HR) department so they can update the eligibility information they provide to us.

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Reimbursement Information

Federal guidelines require coverage of eight (8) OTC COVID tests (the "tests") per individual per consecutive 30-day period **starting on January 15, 2022** and for the duration of the Public Health Emergency. Health Plans are allowed to restrict the reimbursable dollar amount eligible per test when the Health Plan's pharmacy benefits also provide test coverage. Other plan restrictions/exclusions may apply, such as denying reimbursement for tests purchased primarily for travel or employment testing purposes. Your test coverage quantity limit resets every 30 consecutive days. Day 1 of your 30-day period is based on the test purchase date on the first claim that we process. Therefore, it's important to submit your claims for reimbursement to us in the order that you purchased the tests.

Claim Information

Fill in a separate row below for each covered plan member for whom you're seeking OTC COVID test reimbursement.

Full Name of Person for Whom OTC COVID Tests Were Purchased	Purchase Date	# of Tests (*Not* Kits/Boxes) Purchased per Person	Total Charges	Testing Purpose[3] (pick only one per row)
				○ Diagnostic ○ Employment ○ Travel
				○ Diagnostic ○ Employment ○ Travel
				○ Diagnostic ○ Employment ○ Travel

Other Insurance Information

If you have other insurance (OI) and haven't provided us with your OI information in the past year, please fill out and submit the **Other Health Insurance Coverage Form** (located at https://www.accesshma.com/news-and-resources/member-forms)

Attachments

Be sure to include all relevant material (such as receipts) with your submission. Otherwise, your claim might be delayed or denied.

Signature

Note: It's a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

By signing below, I indicate the following:

- I certify that the information I provided on this form is true and complete to the best of my knowledge.
- I expressly authorize any provider of care to provide Healthcare Management Administrators with any records concerning me or any dependent member for whom benefits or services have been claimed.

Printed Name (First and Last)

Relationship to Member (If you are the member, put "Self")

Signature

Date

3 Testing Purpose: For each row, select the *one* main reason why you purchased the OTC COVID test(s):

- **Diagnostic Testing**: You purchased the test(s) primarily to determine if you have COVID due to either exposure or evaluation of symptoms and you don't intend to use the test(s) to fulfill travel or employment-based testing requirements.
- **Employment Testing**: You purchased the test(s) primarily for employment-based testing requirements.
- **Travel Testing**: You purchased the test(s) primarily for travel screening or travel requirements.