Commercial at-home over-the-counter COVID-19 test reimbursement form

Claim Form Instructions

Complete this form for each covered member to request reimbursement for your at-home over-the-counter COVID-19 tests purchased on or after January 15, 2022.

Please read carefully before completing this form. Claim forms without the required information cannot be processed and will be returned to sender. Fields marked with an asterisk (*) are required.

Part 1: Member Information (to be completed by the member)

1. Complete all information under Part 1. The Primary Subscriber/Cardholder ID Number is located on your insurance card.
2. Submit claims within the filing period specified by your health plan. For questions about your filing period, please call the number on the back of your insurance card.
3. Please submit a separate claim form for each member and pharmacy, store, or online retailer from which you purchased the at-home over-the-counter COVID-19 test.
4. IMPORTANT NOTE: Payment and related correspondence will be sent to the primary subscriber unless you provide us with an Alternate Address in Part 1.

Part 2: Receipt

1. Submit at-home over-the-counter COVID-19 test requested information.
2. Include all original pharmacy, store, or online retailer receipt(s). Tape receipts to a separate page to be submitted with the claim form. Note: Please do not staple receipts or other documentation to the claim form.

Part 3: Submission

Send the completed form and receipt(s) to:

MedImpact Healthcare Systems, Inc.
PO Box 509098
San Diego, CA 92150-9098

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CCHP Health Plan

PART 1

*Indicates required information

Primary Subscriber/Cardholder ID Number*		Group Number	
Name of Health Plan/Insurance		Primary Subscriber Name*	DOB: (mm/dd/yyyy)* / /
Member Name: (First, Middle, Last)*		Date of Birth: (mm/dd/yyyy)* / /	Relationship to Primary Subscriber Self ☐ Spouse ☐ Dependent ☐
Primary Subscriber Address: (Street, City, State, Zip code)			
Alternate Address: (Street, City, State, Zip code) ***If no alternate address is specified, correspondence and/or payment will be forwarded to the primary subscriber address on file with your health plan/insurance.**			
Member Telephone Number: ( )			

PART 2

Enter the Required Information

Name of Pharmacy, Store or Online Retailer*	Place of Purchase (on receipt)* (check one) Pharmacy ☐ Other ☐		Telephone Number (pharmacy, store or online retailer)*
Pharmacy Address/Store Address/Online Retailer Website URL			Pharmacy NPI (if purchased at pharmacy)
City	State	Zip	

Date of Purchase* (mm/dd/yyyy) / /	Total cost of Purchase* $	Number of test(s) submitted for reimbursement?*	COVID-19 OTC Test Product Name and/or National Drug Code (NDC) Please list all product name(s) on receipt. If you purchased more than one brand of test, please list all names. Product Name*: _____ Product Name: _____ NDC (if available): _____

I understand that anyone who knowingly or intentionally misrepresents, omits, or falsifies information requested by this form may be found guilty of a crime, and/or subjected to civil or criminal penalties.

I certify that the at-home over-the-counter test(s) requested for reimbursement will not be used for employment purposes, has not been (and will not be) reimbursed by another source, and is not for resale.

By signing below, I certify that I have read and understood this form, and that the information provided on this form is true and correct to the best of my knowledge.

Signature*	Date*

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