COVID-19 Testing
Member Reimbursement Form – Non-Medicare Advantage

Blue Cross Blue Shield Blue Care Network of Michigan

Please use this form to request reimbursement for COVID-19 tests you have paid for out of your own pocket. To be eligible for reimbursement, the following must apply:

- You must provide documentation that the test was ordered or performed by a health care provider.
- The test you received must be approved by the Food and Drug Administration. Check the FDA-approved test list.
- The test was medically necessary. You were exposed to someone with COVID-19, or you have symptoms.
- You must provide documentation of the amount you paid.

Reimbursement will not be approved without all the documentation listed above. All fields below must be completed to enable processing of your request.

Policy Holder Information
You can find your enrollee or member ID on your Blue Cross ID card.

Alpha Prefix	Enrollee ID	Group Number

Policy Holder's Last Name	Policy Holder's First Name

Policy Holder's Street Address

City	State	Zip Code

Patient Information

Last Name	First Name	Date of Birth

Reason for the test:

☐ I was exposed to someone with COVID-19.

☐ I had COVID-19 symptoms.

☐ Other: _____

If you're requesting reimbursement for an at-home test, please provide the following information:

Manufacturer of the test (FDA-approved list): _____

Where was test purchased (for example, Amazon.com)? _____

Date of purchase (MM/DD/YYYY): _____ Cost of the test: $ _____

If you're requesting reimbursement for a test provided by a health care provider, please provide the following information:

Provider type (check one)

☐ Provider's office ☐ Laboratory or mobile lab ☐ Urgent care facility ☐ Pharmacy

☐ Other: _____

Provider's Name: _____

Provider's Address: _____

Provider's National Provider Identifier (NPI): _____

Date of service (MM/DD/YYYY): _____ Cost of the test: $ _____

I certify the above information is true, the enclosed material is correct and unaltered, and the expenses were incurred by the patient listed above. False receipts or altering of this information will result in civil or criminal prosecution. I authorize the release of any information as described below.

Signature	Date	Phone Number

We value your privacy. We won't release any information about you unless you ask us to in writing or we must do so to process or review your claim (by sharing with another insurance company, for example). We'll tell you which information we released and to whom, if you request it.

Please make sure you provide the following documents with this form:

- For at-home tests:
  - Receipt indicating the amount you paid
  - Documentation that a health care provider ordered the test. This can be an email or letter from a doctor, a prescription or other similar documentation
- For tests provided by a health care provider, the original bill or claim for the services that includes:
  - The laboratory or provider's name and address
  - The date of service
  - The appropriate procedure and diagnosis codes
  - The receipt indicating the amount you paid
- Keep copies of your original receipts for your files. We can't return originals to you.

Mail this form to:

Blue Cross Blue Shield of Michigan
COVID Member Reimbursement
Imaging and Support Services
P.O. Box 32592
Detroit, MI 48233