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Medicare Advantage COVID-19 Testing Member Reimbursement Form



Please use this form for repayment of your money used for COVID-19 testing after you received an initial COVID-19 test. To be eligible, the following criteria must apply:

- You must provide documentation that subsequent COVID-19 testing was ordered by a qualified health care provider (doctor, pharmacy, lab or approved testing site).
- The at-home test you received must be approved by the Food and Drug Administration. Check the **FDA-approved test list**.
- The test was medically necessary because you were exposed to someone with COVID-19, or you had 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 this information 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
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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 include the following information:

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

Where was the 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 qualified health care provider, please include 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: _____

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

I certify the information is true for the expenses incurred by the patient listed above, and the enclosed material is correct and unaltered. 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 without your written permission, unless it's 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 requested.

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

- For at-home tests:
 - Receipt indicating the amount you paid
 - Document that a qualified health care provider ordered the test using an email or letter from a doctor, a prescription or other similar documentation
- For tests provided by a qualified 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

Reminder: It's important that you keep copies of your original receipts for your records.

Mail this form to:

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