2022

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 qualify:

- You must provide documentation that subsequent COVID-19 testing was ordered and performed by a qualified health care provider (doctor, pharmacy, lab or approved testing site).
- The 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.
- **At-home tests are only covered for Medicare Advantage members if you collect the sample yourself and send it to a lab for processing**.
- **Over-the-counter or rapid response at-home tests are not covered.**

Reimbursement won't be approved without all the documentation listed above. All fields below must be completed to process 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

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, 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: $_____

Name of processing lab with complete address: _____

If you're requesting reimbursement for a test provided by a qualified health care provider, 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 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.

For tests provided by a qualified health care provider or an at-home test, be sure you've included the following documentation before submitting this form:

- The original bill or claim for the services
- The laboratory or provider's name and address
- The date of service
- 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