COVID-19 OVER-THE-COUNTER (OTC) TESTING
MEMBER REIMBURSEMENT FORM
Non-Medicare Advantage

Kansas City

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:

- The test was self-administered and self-read at home and did not involve a healthcare provider.
- Tests must be authorized, cleared or approved by the FDA. For a list of EUA authorized tests, go **here** and enter OTC into the list search box located under the article titled *Individual EUAs for Antigen Diagnostic Tests for SARS-CoV-2* and above the table. Please note, tests must be self-administered and self-read. Any test that requires a healthcare provider to administer or read is not eligible. The list may be subject to change.
- You must provide a legible copy of the receipt and include all test kit information in the spaces provided below.
- Reimbursement is limited to 8 tests per covered individual per 30-day period.
- Sales tax and delivery charges will not be reimbursed.
- OTC tests purchased prior to January 15, 2022, that do not require a healthcare provider order, are not eligible for reimbursement.
- Incomplete forms will be declined and returned.

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

MEMBER INFORMATION
You can find your member ID and group number on your member ID card.

Member ID (Include 3-Digit Alpha Prefix)	Group Number	Date of Birth
Member's Last Name	**Member's First Name**	
Member's Street Address		
City	**State**	**Zip Code**

PLEASE PROVIDE THE FOLLOWING INFORMATION FOR THE OVER-THE-COUNTER TEST KIT(S) YOU PURCHASED:

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

Where was test purchased (e.g., CVS, Walgreens, Amazon.com)? _____

Test kit UPC or Barcode #: _____

Number of kits: _____ Number of tests per kit: _____ Date of purchase (MM/DD/YYYY): _____

Total cost: $ _____ Includes tests for other covered family members? ☐ Yes ☐ No

By typing your name below, you are signing this application electronically. I am stating that the information above is correct. Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information, may be guilty of a criminal act punishable under law and may be subject to civil penalties. In addition, I attest that any claims for reimbursement for over-the-counter COVID-19 antigen tests will be used for the patient named above for personal use and is not for employment purposes, has not been (and will not be) reimbursed by another source, and is not for resale.

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 you must provide a legible copy of the receipt and include all test kit information in the spaces provided above.
- Keep copies of your original receipts for your files. We can't return originals to you.

EMAIL OR MAIL THIS FORM TO:

COVID@BlueKC.com

Blue Cross and Blue Shield of Kansas City
ATTN: COVID OTC Tests
P.O. Box 419169
Kansas City, MO 64141-6169