The federal government now requires commercial health plans to cover the cost of At Home over-the-counter (OTC) COVID-19 tests for members beginning January 15, 2022. This policy will remain in effect for the duration of the Federal Public Health Emergency.

As the result of a new requirement announced this week, your Employer will now reimburse members for OTC COVID-19 tests.

Member Reimbursement
Members may receive reimbursement for up to eight OTC COVID-19 at-home tests per covered individual in the household per 30-days without a healthcare provider order or clinical assessment. If multiple tests are sold in one package, i.e., if one package includes two tests, it counts as two tests and not one test package toward the quantity limit.

Tests that can be purchased at a retail location or online but are then sent to a lab for processing are not covered unless accompanied by a doctor's order.

To be eligible for reimbursement, the purchased COVID-19 tests:

- must be purchased on or after January 15, 2022
- must be for personal diagnostic use
    - used to identify the potential COVID-19 infection
    - not be used for employment purposes
    - not used for surveillance testing
- will be self-administered with results that can be self-read
- will not be resold, given or supplied to persons other than family members covered under the same policy
- will not be reimbursed by another source

Claims Submission
Members must complete a claim form and mail it to CareFirst Administrators. The address is located on the form as well as the back of your member ID card.

Once you have your claim form:

1. Complete and sign the form
2. Attach the required documentation
3. Mail everything to us according to the directions on the form
   We suggest taking a photo of your forms and documentation for your records.

Required documentation for this claim includes:

- The purchase receipt documenting the date of purchase and price
- UPC* from the OTC COVID-19 test packaging
- Signed, completed attestation confirming and acknowledging that the purchased OTC at-home COVID-19 test meets eligibility guidelines.

The attestation included in our claims process ensures our members comply with the spirit of this policy—to ensure tests are accessible and affordable for those who need them. Buying tests to store them for a potential need isn't good for the community or public health. We ask everyone to respect and protect community health as the supply chain and our health and retail partners catch up with demand.

* The UPC (Universal Product Code) is the barcode and 12-digit-number that typically runs below it.

How to submit your claim for an OTC COVID-19 Test

What Tests are covered? Your employer will cover any OTC COVID-19 test that meets federal requirements, which is self-administered, and the results are read by the member. Tests may be purchased at a retail store or on-line. Tests purchased at a retail location or on-line, which are then sent to a lab for processing, are not covered unless accompanied by a doctor's order (except for residents of plans based in the District of Columbia).

How do I get reimbursed for my OTC COVID-19 test? All required documentation listed below must be submitted to be reimbursed:

- Claim Form
- Original receipt;
- The attestation form attached to these instructions; and
- UPC code cut out from **each** OTC COVID-19 test being submitted. UPC codes should be taped to a sheet of paper.

Example of UPC code: 

Completing the claim form:

The following sections of the claim form must be completed

1. Name of Employee / Employee's Date of Birth / Employee's ID Number
2. Employee's Address
3. Employee's Sex / Employee's Marital Status
4. Employer Name
5. Other Insurance Information (if applicable)
6. Patient's Name / Patient's Date of Birth
7. Patient's Relationship to Employee
8. Patient's Sex
9. Diagnosis, nature of illness or injury – **Enter COVID At-Home Test**
10. Indicate whether the test is related to employment
11. List Below Only Those Charges Being Claimed
    - Name of Provider – **Enter location purchased and name of test**
    - Description of Services – **Enter A9150 and number of tests in the unit (box) purchased. If a box contains 2 test you would enter – 2 tests, if a box contained a single test you would enter 1 test**
    - Diagnosis **– Enter Z11.52**
    - From Date **– Enter date purchased (from receipt)**
    - Charge **– Enter the cost of the COVID test(s) purchased** (you may include tax and standard shipping costs.) Express, Rush or Overnight Shipping charges will not be reimbursed)
12. Total – **Enter the total charges on the claim**
13. **Sign the claim form either electronically or physically**

Example:

16. LIST BELOW ONLY THOSE CHARGES BEING CLAIMED AND ATTACH ORIGINAL ITEMIZED BILLS FROM THE PROVIDER FOR THESE SERVICES

	NAME(S) OF PROVIDER(S)	DESCRIPTION(S) OF SERVICE(S)	DIAGNOSIS (IF MORE THAN ONE)	FROM DATE (MO / DAY / YEAR)	TO DATE (MO / DAY / YEAR)	CHARGE
A.	Walmart / BinaxNOW	A9150 - 2 tests	Z11.52	01 / 15 / 22		$ 24 . 99
B.	RiteAid/iHealth	A9150 - 2 tests	Z11.52	01 / 15 / 22		$ 20 . 50
C.						$.
D.						$.

17. TOTAL $ 45 . 49

MEDICAL CLAIM FORM

INSTRUCTIONS:

1. **Complete Employee's Statement and Attestation Statement below**
2. **Attach ALL required documentation**
3. **Send claim form, attestation and required documentation to:**
   Mail Administrators
   PO Box 981608
   El Paso, TX 79998

EMPLOYEE'S STATEMENT

NAME OF EMPLOYEE (*First name, middle initial, last name*)	EMPLOYEE'S BIRTHDATE	EMPLOYEE'S ID NUMBER (from medical card)
EMPLOYEE'S ADDRESS (NO.) (STREET) (CITY) (STATE) (ZIP)		
EMPLOYEE'S SEX MALE FEMALE	EMPLOYEE'S MARITAL STATUS SINGLE MARRIED DIVORCED LEGALLY SEPARATED	EMPLOYER NAME
IS COVERAGE FOR THIS CLAIM PROVIDED BY ANY OTHER GROUP INSURANWCE, FEDERAL PROGRAM (INCLUDING MEDICARE), EMPLOYER, UNION, STUDENT OR ASSOCIATION PLAN? YES NO IF YES, PROVIDE NAME AND ADDRESS OF INSURANCE COMPANY		POLICY NUMBER
NAME OF PATIENT	PATIENT'S BIRTHDATE	PATIENT'S RELATIONSHIP TO EMPLOYEE ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER
PATIENT'S SEX MALE FEMALE	IF CLAIM FOR A DEPENDENT CHILD, DO YOU HAVE LEGAL CUSTODY? ☐ YES ☐ NO IS CHILD MARRIED? ☐ YES ☐ NO	
DIAGNOSIS, NATURE OF ILLNESS OR INJURY		IS CONDITION RELATED TO EMPLOYMENT? YES ☐ NO

LIST BELOW ONLY THOSE CHARGES BEING CLAIMED AND ATTACH ORIGINAL ITEMIZED BILLS FROM THE PROVIDER FOR THESE SERVICES

	NAME(S) OF PROVIDER(S)	DESCRIPTION(S) OF SERVICE(S)	DIAGNOSIS (IF MORE THAN ONE)	FROM DATE MO DAY YEAR	TO DATE MO DAY YEAR	CHARGE
A.				/ /	/ /	$.
B.				/ /	/ /	$.
C.				/ /	/ /	$.
D.				/ /	/ /	$.
					TOTAL	$.

AUTHORIZATION: The above answers are true and correct to the best of my knowledge. I hereby authorize any physician, practitioner or other person, any hospital, including veteran's administration or government hospital, any medical service organization, any insurance company, or other institution, or organization, to release to each other any medical or other information acquired, including benefits paid or payable, concerning this or other liabilities. A photostat of this authorization shall be as valid as the original.

DATE _____ EMPLOYEE'S SIGNATURE _____ PATIENT'S SIGNATURE (PARENT OR GUARDIAN IF PATIENT IS A MINOR) _____

Attestation Statements for OTC At-Home Rapid Antigen COVID Tests

Member ID:_____ Patient Name: _____

Under a requirement of the federal government, your Employer will now reimburse members for over-the-counter (OTC), at-home COVID-19 tests. **The federal mandate only applies to tests purchased to identify potential COVID-19 infection.** OTC COVID-19 tests used for surveillance testing and employment purposes are not covered.

Please initial each item below and attach this document to your claim form.

_____ I agree that the expenses for the OTC at-home COVID-19 test(s) are correct and were incurredby the above-named member.

_____ I agree that the OTC at-home COVID-19 test(s) was purchased on or after January 15, 2022.

_____ I agree that the purchase of the OTC at-home COVID-19 test(s) listed above are not for surveillance, or for the purposes of my employment. (e.g., satisfying an employer's requirementto test weekly).

_____ I agree that the expenses listed on the claim form for the OTC at-home COVID-19 test(s) have not been, nor will they be, reimbursed from another source, including employer, school, HSA/FSA or other insurer.

_____ I agree that I will not resell, give or supply the OTC at-home COVID-19 Test(s) to any other persons or entities other than my family members covered by my employer's health plan.