Health Alliance NORTHWEST™

Reimbursement Request Form for Over-the-Counter COVID-19 Home Test Kits

This form is to be used for reimbursement of Over-the-Counter (OTC) COVID-19 home test kits purchased at a retail store or pharmacy. It should not be used for OTC COVID-19 diagnostic tests purchased to satisfy employment-based screening requirements.

A. Member Information

Member Name _____

Member ID Number _____

Member DOB _____

Member Address _____

Member City, State, Zip _____

B. Store Information

Name of Store _____

Store Address _____

Store City, State, Zip _____

Date Purchased _____

Complete the grid below for boxes purchased on the above date.

List each box separately.

Box Number	Test Kit Brand	Number of Tests in the Box	Total Paid
1			
2			
3			
4			
5			
6			
7			
8			

Note 1: The original store receipt and the original UPC proof of purchase panel from the OTC COVID-19 test box MUST be included with this Reimbursement Request Form in order to be processed. **Photocopies or pictures of receipts or UPC proof of purchase panels are not acceptable.**

Note 2: Reimbursement will be in the amount of $12 per test or purchase price of the test, whichever is less.

Note 3: Limit 8 tests per member per calendar month.

Mail this completed form along with the original receipt and box barcodes to:

Health Alliance Medical Plans, Inc.

Attention: Claims Department

P.O. Box 6003

Urbana, IL 61803

Questions?

These actions, guidelines and limits may change as the pandemic evolves. Please call the number on the back of your health plan ID card if you have any questions about your coverage.