



A UnitedHealthcare Company

## Over-the-counter (OTC) at-home COVID-19 test kit reimbursement form

You can use this form to ask us to pay you back for over-the-counter at-home COVID-19 test kits that have been authorized by the federal Food and Drug Administration (FDA).

- This form is for OTC COVID-19 test kits purchased by you.
- Print your responses in black or blue ink. You can also complete the form using a computer and print and mail us the completed form.
- Include proof of payment (such as a paid receipt) that includes the name of the test kit along with this completed form. If we don't receive the required information, your request will not be processed.
- Send the completed form and proof of payment to the address on the back of your health plan ID card.

### Information about the member who used the OTC COVID-19 test kit

Full name \_\_\_\_\_

What is your relationship to the subscriber/policyholder?

Spouse/partner

Child

I am the subscriber/policyholder

Other

### Subscriber/policyholder information

Complete this section if it's different than the member information above.

Full name \_\_\_\_\_

Member ID \_\_\_\_\_ Plan/group # \_\_\_\_\_

Date of birth \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Is this a new address?      Yes      No

Phone number ( \_\_\_\_\_ ) \_\_\_\_\_

Email address \_\_\_\_\_

### Information about your OTC COVID-19 test kit

How many test kits are you submitting for reimbursement?      1 test      2 tests      3 tests or more

Name of the FDA authorized test kit purchased (e.g., BinaxNOW, QuickVue, Intelliswab, etc.) \_\_\_\_\_

Purchase date(s) \_\_\_\_\_

(More information on back)

## Member signature

Signature \_\_\_\_\_

Date \_\_\_\_\_

/ /

**When I sign above, 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.**

## Ready to send the completed form?

Please send the completed form and proof of payment to the address on the back of your health plan ID card.



### Before you put it in the mail, make sure you:

- Completed and signed the form
- Included proof of payment, such as a paid receipt
- Kept a copy of everything you send us



### Questions? We're here to help.

If you have any questions, please call the member phone number on your health plan ID card.