Over-the-Counter (OTC) At-home COVID-19 Test Reimbursement Form

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

- This form is for OTC COVID-19 tests purchased by you.
- Print your responses in black or blue ink.
- Include proof of payment (such as an itemized receipt) that includes the name of the test along with this completed form.
- If we don't receive the required information, your request will not be processed.
- Complete a separate form for each family member

Ready to send the completed form?

Please send the completed form and proof of payment (such an itemized receipt) to:

Bind Claims
P.O. Box 211758
Eagan, MN 55121

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

- Complete and sign the form
- Include proof of payment, (such as an itemized receipt)
- Original or a copy is accepted. Keep 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.

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Information about the member who used the OTC COVID-19 test(s)

Full name ____

Member ID _______________________________Date of birth ______/_____/_______

What is the member's relationship to the subscriber/policyholder?

☐Spouse/partner ☐ Child ☐ I am the subscriber/policyholder ☐Other_________

Subscriber/policyholder information

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(s)

How many individual tests are you submitting for reimbursement? _________

*Some kits/boxes have more than 1 test.

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

____

Purchase date ______/_____/_______
(dd / mm / yyyy)

Total amount you paid for test(s) as shown on the attached receipt $__________________

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.

Internal Processing

Procedures:
- OTC: 87426 (Antigen test; sample and results at home)
- Home test kits: 87635 (PCR test; sample at home and results in a lab)

Dx: Z20.828 **POS:** 12

Provider NPI: 8888888888 (10 characters) **Billing provider name:** COVID 19 OTC Test Kit
TIN: as 999999999 (9 characters) **Provider network:** Member Submitted Claim **Network**
Repricing code: MSC

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