COVID-19 Over-the-Counter (OTC) Test Kit Claim Form

Use for COVID-19 over-the-counter (OTC) testing kits only.
Please complete one form per member.

Use this form to request reimbursement for OTC COVID-19 tests you have paid for out of your own pocket. To be eligible for reimbursement, your test must be authorized by the Food and Drug Administration (FDA). You must provide a detailed receipt, showing the brand name of the Covid-19 test kit, the number of tests included in each kit, the amount paid, and follow the guidelines below.

At-home rapid diagnostic COVID-19 tests that are self-administered and self-read, Effective January 15, 2022:

- There is a limit of up to 8 tests per covered member/dependent, per calendar month (based on the date of purchase).
- Testing for employment or travel purposes is not covered and will not be reimbursed.

Section 1: Subscriber Information

You can find your subscriber or member ID on your Anthem ID card.

Subscriber ID Number :	Group Number :
Subscriber's Last Name :	Subscriber's First Name:
Street Address :	
City State Zip Code :	
Telephone Number :	
Email :	

Section 2: Patient Information

Name of person completing the test

Last Name :	First Name :
Date of Birth :	
Relationship (Please check one) : ☐ Self ☐ Spouse ☐ Domestic Partner ☐ Child	

Section 3: Describe the Test Kit(s)

Please answer the following questions about the test(s) for which you are seeking reimbursement.

Please select the response that best describes the type of test for which you are seeking reimbursement.

☐ An at-home, over-the-counter (OTC) rapid result test, visually read and results interpreted by the member.

☐ An at-home, specimen collection kit where the specimen is sent to a lab or other facility for processing and interpretation of results.

(**STOP**: This form should not be used to request reimbursement for specimen collection kits processed by a Lab or other facility. Use the standard medical claim form instead.)

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Please select the OTC at-home product/brand you purchased (select all that apply)

☐ BD Veritor At-Home COVID-19 Test (Becton Dickinson)
☐ BinaxNOW COVID-19 Antigen Self-Test (Abbott)
☐ CareStart COVID-19 Antigen Home Test (Access Bio)
☐ Celltrion DiaTrust COVID-19 Ag Home-Test
☐ ClearDetect COVID-19 (MaximBio)
☐ CLINITEST Rapid COVID-19 Antigen Self-Test (Siemens)
☐ COVID-19 At-Home Test (SD Biosensor)
☐ Ellume COVID-19 Home Test (Ellume)
☐ Flowflex COVID-19 Antigen Home Test (ACON)
☐ iHealth COVID-19 Antigen Rapid Test (iHealth Labs)
☐ InteliSwab COVID-19 Rapid Test (OraSure)
☐ QuickVue At-Home OTC COVID-19 Test (Quidel)
☐ SCoV-2 Ag Detect Rapid Self-Test (InBios)
☐ Other____

Date of Purchase: __________ Number of Boxes: ________Tests per Box:________Total Cost: $____________

Section 4: Member Attestation

Please check yes or no for all of the following questions.

The OTC test kit submitted for reimbursement on this form:

Yes	No	
☐	☐	Was purchased for personal use for the member or for a covered dependent
☐	☐	Was purchased for employment purposes
☐	☐	Has been (or will be) reimbursed by another source
☐	☐	Has been (or will be) placed for resale

Member signature____Date_______________

When I sign above, I am stating that the information above is true and correct. Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete, or misleading information may be deemed to have defrauded the Trust, and be subject to future loss of eligibility.

Section 5: Required Documentation

When submitting your OTC test-kit claim, please include the required documentation with your form. Incomplete submissions may not be considered for reimbursement.

- Purchase receipt clearly showing the date of purchase, where purchased and testing kit charges.
- Photo of the rapid antigen home test box and the QR or UPC code from the box

SUBMISSION INSTRUCTIONS

Send your completed claim form and receipt to:
By Mail : IBT of PORAC 2960 Advantage Way, Sacramento, CA 95834
By Email : Healthplan@ibtofporac.org