selecthealth ADVANTAGE

P.O. Box 30196 Salt Lake City, UT 84130-0196 **855-442-9900 selecthealthadvantage.org**

COVID-19 OTC Test Claim Reimbursement Form

A. MEMBER INFORMATION

You may use this form to request reimbursement of Over-the-Counter (OTC) COVID-19 antigen tests that have been authorized by the Federal Drug Administration (FDA). This form is only for SelectHealth Advantage members who purchased a test per a healthcare provider's order. Documentation of a healthcare provider's order is required for reimbursement. If you have questions, please call Member Services at **855-442-9900 (TTY: 711)**.

Member ID # (found on your SelectHealth ID card) _____

Member's Name _____

Member's Date of Birth _____ (MM/DD/YY) Member's Phone #_____

Member's Address _____

Member's City _____ Member's State _____ Member's ZIP _____

B. OTHER INSURANCE INFORMATION

Do you have other insurance besides SelectHealth? ❑ Yes ❑ No

If yes, please complete the following:

Insurance Company _____

Is this your primary insurance? ❑ Yes ❑ No

Other Insurance Company Policy ID # _____

Policyholder's Name _____ Policyholder's Date of Birth _____ (MM/DD/YY)

Relationship to Policyholder: ❑ Self ❑ Spouse ❑ Dependent

C. CLAIM INFORMATION

COVID-19 Antigen Test Manufacturer Name _____ Required

Ordering Provider's First and Last Name (Required) _____

Date of Purchase _____ (MM/DD/YY) Test Purchase Amount (Before Tax) $_____._____

Tax Associated With Test Purchase Amount $_____._____

Test Quantity (# of Individual Tests) _____

Note: Please enclose documentation of the healthcare provider's order per Section E below. Members cannot submit claims for future months and seek reimbursement. SelectHealth does not reimburse shipping and handling costs of OTC COVID-19 tests.

D. RECEIPT

Please enclose a copy of your receipt.

E. PROVIDER ORDER *(Required)*

Please enclose documentation of a provider order.

F. MEMBER SIGNATURE

Signature _____ Date _____
(MM/DD/YY)

By providing my signature, I am stating that the information I have provided on this form is correct. If I knowingly filed this statement of claim and provided any misrepresentation or any false, incomplete, or misleading information, I may be guilty of a criminal act punishable under law and may also be subject to civil penalties.

Reimbursement Form Instructions

To ensure that your benefits are administered correctly and without delay, complete all of the information on this form. Enclose a copy of your receipt and provider's order with this form. If you are submitting multiple receipts, one reimbursement form is required for each receipt. Please keep a copy of your completed form and all associated materials that you send to us.

Submit claims to the address below:

SelectHealth
P.O. Box 30196
Salt Lake City, Utah 84130-0196

Claims submitted without the proper identification numbers may be delayed or returned for additional information. If you have questions, call Member Services at **855-442-9900** weekdays, from 7:00 a.m. to 8:00 p.m., and Saturday, from 9:00 a.m. to 2:00 p.m. TTY users, please call 711.

SelectHealth obeys federal civil rights laws. We do not treat you differently because of your race, color, ethnic background or where you come from, age, disability, sex, religion, creed, language, social class, sexual orientation, gender identity or expression, and/or veteran status.

This information is available for free in other languages and alternate formats.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電

SelectHealth Advantage: 855-442-9900 (TTY: 711)