selecthealth

P.O. Box 30192 Salt Lake City, UT 84130-0192 **800-538-5038** **selecthealth.org**

COVID-19 OTC Test Claim Reimbursement Form

A. SUBSCRIBER INFORMATION

You may use this form to request reimbursement of over-the-counter COVID-19 antigen tests that have been authorized by the Federal Drug Administration (FDA). This form is only for members who get their insurance through their employer or who purchase an Individual commercial plan from SelectHealth. If you have questions, please call Member Services at **800-538-5038**.

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

Subscriber's Name _____

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

Relationship to Subscriber: ❑ Self ❑ Spouse ❑ Dependent

Subscriber's Address _____

Subscriber's City _____ Subscriber's State _____ Subscriber's ZIP _____

B. OTHER INSURANCE INFORMATION

Does the subscriber have other insurance besides SelectHealth? ❑ Yes ❑ No

If yes, please complete the following:

Insurance Company _____ Is this the subscriber's primary insurance? ❑ Yes ❑ No

Other Insurance Company Policy ID # _____

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

Relationship to Subscriber: ❑ Self ❑ Spouse ❑ Dependent

C. CLAIM INFORMATION

COVID-19 Antigen Test Manufacturer Name _____ *Required*

Was this test ordered by your healthcare provider? ❑ Yes ❑ No *If YES, please enclose documentation of the provider's order per Section E. below.

Ordering Provider's First and Last Name (If applicable) _____

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

Tax Associated With Test Purchase Amount $ _____._____ Test Quantity (# of Individual Tests) _____

NOTE: Claims that exceed the eight-test per-member-per-month limit will be denied. 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 *(If applicable)*

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 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 30192
Salt Lake City, Utah 84130-0192

Claims submitted without the proper identification numbers may be delayed or returned for additional information. If you have questions, call Member Services at **800-538-5038** 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) / SelectHealth: 800-538-5038