COVID-19 Testing
Member Reimbursement Form – Non-Medicare Advantage

Blue Cross Blue Shield Blue Care Network of Michigan

Please use this form to request reimbursement for COVID-19 tests you have paid for out of your own pocket. Submit one form per member. To be eligible for reimbursement, your test must be authorized by the Food and Drug Administration, you must provide documentation of the amount you paid (like a receipt) and follow the guidelines below.

For at-home rapid diagnostic COVID-19 tests:

- There is a limit of 8 tests per member per month (based on the date of purchase).
- Testing for employment purposes is not covered and will not be reimbursed.

  NOTE: If you bought the test prior to Jan. 15, 2022, you must also include documentation that the test was ordered by a health care provider.

For all health care provider administered tests, additionally:

- You must provide documentation that the test was ordered or performed by a health care provider.
- The test was medically appropriate as determined by a licensed or authorized provider.

Reimbursement will not be approved without all the documentation listed above. All fields below must be completed to enable processing of your request.

Subscriber Information

You can find your subscriber or member ID on your Blue Cross ID card.

Three character prefix	Subscriber ID (Required)	Group Number

Subscriber's Last Name (Required)	Subscriber's First Name

Subscriber's Street Address

City	State	Zip Code

Patient Information

Last Name	First Name	Date of Birth

Reason for the test (if health care provider ordered and authorized):

☐ I was exposed to someone with COVID-19.

☐ I had COVID-19 symptoms.

☐ Other: _____

If you're requesting reimbursement for an at-home test, please provide the following information:

Manufacturer of the test: _____

Where was test purchased (for example, Amazon.com)? _____

Date of purchase (MM/DD/YYYY): _____ Reimbursement amount requested: $ _____

How many tests in total were purchased? _____

Please indicate the number of tests in total, not number of boxes. For example, 1 box was purchased with 2 tests, indicate 2 tests in total.

By submitting this form, I attest that these at home tests are not being used for employment purposes.

If you're requesting reimbursement for a test provided by a health care provider, please provide the following information:

Provider type (check one)

☐ Provider's office ☐ Laboratory or mobile lab ☐ Urgent care facility ☐ Pharmacy

☐ Other: _____

Provider's Name: _____

Provider's Address: _____

Provider's National Provider Identifier (NPI): _____

Date of service (MM/DD/YYYY): _____ Cost of the test: $ _____

I certify the above information is true, the enclosed material is correct and unaltered, and the expenses were incurred by the patient listed above. False receipts or altering of this information will result in civil or criminal prosecution. I authorize the release of any information as described below.

Signature	Date	Phone Number

We value your privacy. We won't release any information about you unless you ask us to in writing or we must do so to process or review your claim (by sharing with another insurance company, for example). We'll tell you which information we released and to whom, if you request it.

Please make sure you provide the following documents with this form:

- For at home tests, please make sure you provide a receipt indicating the amount you paid, date of purchase and where you purchased the test.
- For tests provided by a health care provider, the original bill or claim for the services that includes:
  - The laboratory or provider's name and address
  - The date of service
  - The appropriate procedure and diagnosis codes
  - The receipt indicating the amount you paid
- Keep copies of your original receipts for your files. We can't return originals to you.

Mail this form to:

Blue Cross Blue Shield of Michigan
COVID Member Reimbursement
Imaging and Support Services
P.O. Box 32592
Detroit, MI 48233