Harvard Pilgrim Health Care

Member Reimbursement Form

COVID-19 At-home Test

For purchases made on or after January 15, 2022, please complete this form to be reimbursed for over-the-counter COVID-19 at-home tests. Only at-home tests that have an Emergency Use Authorization (EUA) from the FDA are eligible for reimbursement. Check our FDA/EUA chart on our website.

Get started now

1 Complete one form per family member per claim.

2 To be eligible for reimbursement, the test must be for individualized diagnosis or treatment of COVID-19 (not for resale), and not for employment purposes. Reimbursement is permitted for up to eight over-the-counter COVID-19 at-home tests per member per calendar month, when administered without an individualized clinical assessment or a health care provider's involvement. No reimbursement from secondary resellers is permitted and tests must be sold through a bona fide retailer, for example Walgreens, CVS, Walmart, etc.

3 Submit the following to the address listed at the end of this form (any missing information may result in delay or denial of the reimbursement):

a. This completed and signed reimbursement form

b. Proof of payment for the COVID-19 at-home tests being requested for reimbursement

Reimbursement will be sent to the member at the address the Plan has on record. To view your address of record, please log on to www.harvardpilgrim.org or call Member Services at the number listed on your ID card.

NOTE No reimbursement is available for tests already reimbursed through a flexible spending account (FSA) or health reimbursement account (HRA). Expenses for which you are reimbursed under a health plan may be ineligible for tax-free reimbursement under a Health Savings Account (HSA). Questions concerning HSA taxation should be referred by you to a personal tax advisor at your own expense.

**Required fields*

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Member information

By providing your contact information below, you agree to be contacted by us via email and/or phone regarding your plan benefits and administration. Address is required for reporting purposes only. Reimbursement will still be sent to the address the plan has on record.

*Last name	*First name	Middle initial

*Street address

*Town/City	*State	*ZIP code

*Member's health plan ID #	*Date of birth (MM/DD/YYYY)

Email address	Mobile phone number	Home phone number

*Required fields

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At-home test purchase information

Please note that some test kits may contain multiple tests in a box. Please indicate how many tests are per box below.

*Brand name of at-home test (e.g., iHealth, BinaxNow, etc.)	SKU/ UPC (optional)	*Number of boxes	*Number of tests per box	*Date(s) of purchase (MM/DD/YY)	*Amount paid
					$
					$
					$
					$
					$
					$
					$
					$
	*Applicable standard shipping, handling and taxes				$
				*Total	$

*Required fields

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Member signature (required)

I attest that the above information is true and accurate and that the over-the-counter at-home COVID-19 tests submitted for reimbursement were purchased by me from an originating seller in the amount requested as indicated above. I further attest that these at-home tests are for personal use, intended for individualized diagnosis or treatment of COVID-19 (not for resale), and are not for employment purposes. I further attest that these tests have not been and will not be reimbursed by another source, including an FSA or an HRA and that I am not entitled to reimbursements for tests I did not pay for (e.g., free test kits from the state or federal government). Moreover, I attest that this request does not exceed coverage for more than eight (8) COVID-19 tests per member per calendar month, as described above, from Harvard Pilgrim Health Care as a reimbursement or as coverage through a preferred pharmacy.

I acknowledge that there may be consequences for submitting any false or misleading information as described in my Explanation of Coverage or Member Handbook. I understand that reimbursement payment will be made to the person listed above and will contain information about the service (e.g., date, brand name). I also understand that Harvard Pilgrim Health Care may request any additional information it deems necessary to verify that the tests were received for the covered purpose and payment was made.

*Signature (Subscriber signature if Member is a minor)	*Date (MM/DD/YY)

Let's double check

- ☐ I have completed and signed this form in its entirety.
- ☐ I have enclosed proof of payment.
- ☐ I understand that most completed reimbursement requests are processed within 30 days.
- ☐ I have kept copies of my original receipts for my records.

Mail this form and proof of payment to:

Harvard Pilgrim Health Care
P.O. Box 699183
Quincy, MA 02269

For internal use only
Procedure code: 87811
Diagnosis code: Z11.52
Modifier: 32

**Required fields*