COVID-19 At-home Testing Member Reimbursement Form

Please use this form to request reimbursement for COVID-19 tests you have paid for out of your own pocket. To be eligible for reimbursement, the following must apply:

+ The test you received must be approved or authorized by the Food and Drug Administration. Check the FDA-approved/authorized test list.
+ The test was medically necessary. You were exposed to someone with COVID-19, or you have symptoms.
+ You must provide documentation of the amount you paid.

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

Policy Holder Information You can find your member ID on your Providence Health Plan ID card.		
Member ID		Group Number
Policy Holder's Last Name	Policy Holder's First Name	
Policy Holder's Street Address		
City	State	Zip Code

Patient #1 Information		
Last Name	First Name	Date of Birth

Reason for the test:

☐ I was exposed to someone with COVID-19.

☐ I had COVID-19 symptoms.

☐ Other: ____

Patient #2 Information (if applicable)

Last Name	First Name	Date of Birth

Reason for the test:

☐ I was exposed to someone with COVID-19.

☐ I had COVID-19 symptoms.

☐ Other: ____

At-home Test - Reimbursement Information

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

Manufacturer of the test (FDA-approved list): ____

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

Date of purchase (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(s) 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:

+ 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:

Providence Health Plans
ATTN: Pharmacy Claims
P.O. BOX 3125
Portland, OR 97208-3125