Over-The-Counter (OTC) COVID-19 At-Home Test Member Medical Reimbursement Form

(Use this form for tests purchased at non-pharmacy retailers)

Please use this form to request reimbursement for OTC COVID-19 at-home tests you have paid for out of your own pocket **Jan 15, 2022 - May 11, 2023**. To be eligible for reimbursement, the following must apply:

1. The test you received must be approved or authorized by the Food and Drug Administration.
2. You must provide an itemized receipt with the amount you paid for the test.

Reimbursement will be approved when we receive this completed form with your receipt of purchase.

Reimbursement is limited to the purchase of **8 tests per covered member** over a 30-day period.

Please note that shipping costs do not apply to reimbursement.

Subscriber information

You can find your subscriber ID on your Moda Health ID card.

Subscriber ID	Group number	
Subscriber's last name	Subscriber's first name	
Subscriber's street address		
City	State	ZIP

Manufacturer of the test (FDA-approved or authorized): _____

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

Date of purchased (MM/DD/YYYY): _____ Number of tests: _____ Total cost: _____

Member #1 information (if applicable)

Last name	First name	Date of birth

Manufacturer of the test (FDA-approved or authorized): _____

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

Date of purchased (MM/DD/YYYY): _____ Number of tests: _____ Total cost: _____

Member #2 information (if applicable)

Last name	First name	Date of birth

Manufacturer of the test (FDA-approved or authorized): _____

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

Date of purchased (MM/DD/YYYY): _____ Number of tests: _____ Total cost: _____

Member #3 information (if applicable)

Last name	First name	Date of birth

Manufacturer of the test (FDA-approved or authorized): _____

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

Date of purchased (MM/DD/YYYY): _____ Number of tests: _____ Total cost: _____

I certify that these tests are for personal use and are not for employment purposes. I certify the above information is true, the enclosed material is correct and unaltered, and the expenses were incurred by the member(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.

Subscriber signature required	Date	Phone number
X		

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:

1. Itemized receipt(s) listing the tests you purchased and indicating the amount you paid.
2. If you are mailing the form and receipt, please keep copies of your original receipt(s) for your files. We can't return originals to you.

Email this form and receipt(s) to:

medical@modahealth.com

Please include "At-home test reimbursement" in the subject line.

Mail this form and receipt(s) to:

Moda Health
P.O. Box 40169
Portland, OR 97204