



At-Home Over-the-Counter COVID-19 Test Reimbursement Instructions

Use this form only to submit a reimbursement request for your at-home over-the-counter (OTC) COVID-19 tests directly to Community Health Options. Each covered Member in your household is eligible for up to eight (8) individual at-home OTC COVID-19 tests every 30 days. In many cases, tests are packaged together. Each test must be counted individually for reimbursement. If tests are packaged with two tests, one package equals 2 individual tests.

Instructions: Complete this form in its entirety and mail it to Community Health Options, with a copy of the store (seller of the test) receipt(s) and the UPC (bar) code(s) from the test package to qualify for reimbursement.



Step 1: Complete **all** areas of the *At-Home OTC COVID-19 Test Reimbursement Form*. Use your Member ID card(s) to provide the following information: the subscriber's name and ID number, and the Members' names, and ID numbers. Please include information on where and when the COVID-19 tests were purchased.

Step 2: Compile copies of your itemized receipt(s) and UPC (bar) codes for the tests purchased. Please write the Member's name and Member ID number on each receipt and UPC code.

Step 3: Mail your completed form and corresponding receipts and UPC codes to:

Community Health Options, Mail Stop 200, PO Box 1121, Lewiston, ME 04243



**At-Home Over-the-Counter
COVID-19 Test
Reimbursement Form**

Your reimbursement request may be denied if information is missing on the form below, or if proof of payment and the test(s) UPC code(s) are not included. If you have any questions, please contact Member Services at (855) 624-6463.

SUBSCRIBER INFORMATION			
Last Name	First Name	Member ID Number	
Mailing Address	City	State	Zip Code

MEMBER INFORMATION (List each family member separately)				
Last Name	First Name	Date of Birth	Member ID Number	Qty of Test Kits Purchased

COVID-19 TEST INFORMATION			
Purchase Location*	Brand/Manufacturer	Qty of Test Kits in Box	Amount Paid

*Tests must be purchased from a licensed retailer. Tests purchased from individuals or thru sites like Facebook and Ebay will not be reimbursed.

ATTESTATION AND SIGNATURE		
<p>I attest that the above information is true, accurate, and complete to the best of my knowledge, and that the items were paid for in the amount indicated above. I also attest that the tests are for personal use; not for employment requirements, not for resale, and that I have not been, and will not be, reimbursed from any other source. I acknowledge that if any information on this form is misleading or fraudulent, my coverage may be canceled and I may be subject to criminal and/or civil penalties for false healthcare claims. I understand that when the reimbursement is processed it will contain information about the tests purchased (e.g., manufacturer, purchase location, date, and price) for myself and/or my covered dependents. I also understand that Community Health Options may request additional information it deems necessary to process the reimbursement of the COVID-19 tests.</p>		
Print Name	Member/Guardian Signature	Date

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