COVID-19 Over-the-Counter Test Reimbursement Mandate FAQs

What is the Over-the-Counter Test Reimbursement Mandate?

The Biden Administration announced new federal guidance on Jan. 10, 2022 that people with employer-sponsored or individual health insurance coverage can seek reimbursement for the purchase of over-the-counter COVID-19 tests from their employer group or health insurer effective Jan. 15.

What does the Over-the-Counter Test Reimbursement Mandate Cover?

Over-the-counter, at-home, diagnostic tests that are approved by the FDA can qualify for reimbursement. Per federal guidelines, Highmark members can seek reimbursement for up to 8 qualifying tests per month per member. That means a family of four can be reimbursed for 32 tests per month.

Note: Tests may be packaged individually or with multiple tests in one package (for example, two tests packaged in one box). Plans are required to cover 8 tests per covered individual per month, regardless of how they are packaged and distributed.

Who is eligible for the Over-the-Counter Test Reimbursement?

HNAS covered members with employer-sponsored coverage can seek reimbursement for the purchase of over-the-counter COVID-19 tests.

What documentation is needed to submit a request for an over-the-counter test reimbursement?

You will need to submit the following documentation, following the instructions below, to receive reimbursement for your over-the-counter test:

- Completed Member Submitted Health Insurance Claim Form
- Itemized receipt for your over-the-counter tests with purchase date on or after 1/15/2022

- Original or photocopy of UPC (Universal Product Code) label from your purchased over-the-counter tests

How do I get reimbursed for over-the-counter tests?

BSCA Claim forms can be mailed to the address listed on the back of your ID Card. This claim form can be found on myhnas.com.

*NOTE: ** By submitting a manual claim for reimbursement of an over-the-counter COVID-19 test, the member is attesting that it was purchased for personal use, not for employment purposes, and will not be reimbursed by another source or used for resale **

blue of california

Subscriber's Statement of Claim

Send this claim to: Blue Shield of California, P.O. Box 272540, Chico, CA, 95927-2540.

This form is to be used only when the provider of service does not submit your claim directly to Blue Shield.

Check with the Provider to be sure no claim has been submitted.

Duplicate claims will not only be rejected but may delay payment of the original claim.

Important instructions

- Use a separate form for:
  A. Each member of the family
  B. Each different provider of service
  C. Each itemized bill
- Print or type
- Fill in all items completely
- Sign your name in the space provided

Failure to comply with these instructions may result in your claim being delayed or returned to you.

Exceptions:

- Primary Medicare coverage
  A. Submit claim to Medicare first.
  B. Complete boxes 1 and 4 only.
  C. Attach your explanation of Medicare benefits form and a copy of itemized services to this claim and send all to Blue Shield.
- Foreign claims
  Any services rendered outside of the United States or its territories must include the US currency exchange rate or value and the translation for all billed services.

1

Subscriber name (Last, First, MI)	Subscriber number	Group number

Mail address	City	State	ZIP	Is address new? ☐ Yes ☐ No

2

Patient's name	Date of birth (mo/day/yr)	Gender ☐ Male ☐ Female	Relationship to subscriber ☐ Self ☐ Spouse ☐ Child

Describe briefly patient's illness or injury and, if injury, how it occured

Patient was treated for ☐ Injury ☐ Illness ☐ Pregnancy	Date of injury, onset of illness or pregnancy	Is patient retired? ☐ Yes ☐ No	If Yes, effective date

3

Does patient have other health coverage? ☐ Yes ☐ No	If Yes, policy ID number	Name of insuring company	Effective date

Address of insuring company	Type of plan ☐ Group ☐ Individual

Name of policy holder	Gender ☐ Male ☐ Female	Date of birth (mo/day/yr)	Name of employer

4

Was condition related to employment? ☐ Yes ☐ No	Does patient have Medicare? ☐ Yes ☐ No	If Yes, date of birth (mo/day/yr)	Part A effective date	Part B effective date

Subscriber's signature

I certify that the foregoing information is accurate and complete, and authorize the release of any medical information necessary to process this claim.

X _____ Date _____