MASSACHUSETTS

COVID-19 AT-HOME TEST REIMBURSEMENT

Eligible members can get reimbursed for the cost of FDA-authorized, at-home COVID-19 tests. Members can request reimbursement for up to eight tests each month, for purchases made on or after January 15, 2022. Submit a separate form for each covered member, including dependents.

SUBSCRIBER INFORMATION (POLICYHOLDER)

ID NUMBER ON SUBSCRIBER ID CARD (including first 3 characters)	SUBSCRIBER'S LAST NAME	FIRST NAME	MIDDLE INITIAL

ADDRESS – NUMBER AND STREET	CITY

STATE	ZIP CODE	EMPLOYER'S NAME

CLAIM INFORMATION

MEMBER'S LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH

CLAIM IS FOR (CHOOSE ONE AND COLOR IN THE ENTIRE BOX):

☐ **SUBSCRIBER** (POLICYHOLDER) ☐ **SPOUSE** (OF POLICYHOLDER) ☐ **EX-SPOUSE** ☐ **DEPENDENT** (UP TO AGE 26)

☐ **OTHER** (SPECIFY): _____

Tests purchased in a multi-pack count as multiple tests, and must be listed individually in the spaces provided below. For example, if you paid $20 for a two-pack of tests, you'll need to enter the information on two separate lines, at $10 each.

SAVE YOUR RECEIPTS, AND FILL OUT THE FOLLOWING:

	NAME OF RETAILER	DATE OF PURCHASE	AMOUNT PAID	BRAND NAME
1				
2				
3				
4				
5				
6				
7				
8				

Important Information:

- This form can be used for tests purchased from January 15, 2022 through January 22, 2022. An updated submission form will be available on January 23, 2022.
- Keep copies of receipts in case we request them from you.
- Blue Cross Blue Shield of Massachusetts will make a reimbursement decision within 30 calendar days of receiving a completed request form.
- Reimbursement is sent to the member's address on file with Blue Cross. Reimbursement may be considered taxable income, so you should consult your tax advisor.

Certification and Authorization (This form must be signed and dated below.)

I certify that the information provided in support of this submission is complete and correct, and that I have not previously submitted for these purchases.

I understand that Blue Cross Blue Shield of Massachusetts may require proof of payment for a reimbursement decision. I authorize the release of any information about purchases to Blue Cross Blue Shield of Massachusetts. By submitting this claim for reimbursement, you are attesting it was purchased for personal use, not for employment purposes, and will not be be resold.

SUBSCRIBER'S OR MEMBER'S SIGNATURE: _____ **DATE:** _____

COMPLETE THIS FORM AND EMAIL IT OR SEND IT TO:
COVIDTestClaims@BCBSMA.com **or** Blue Cross Blue Shield of Massachusetts, Local Claims Department, PO Box 986030, Boston, MA 02298.

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