Health Alliance™

Reimbursement Request Form for Over-the-Counter COVID-19 Home Test Kits

This form is to be used for reimbursement of Over-the-Counter (OTC) COVID-19 home test kits purchased at a retail store or out-of-network pharmacy. It should not be used for OTC COVID-19 diagnostic tests purchased to satisfy employment-based screening requirements or for public surveillance purposes.

A. Member Information

Member Name _____

Member ID Number _____

Member DOB _____

Member Address _____

Member City, State, Zip _____

B. Store Information

Name of Store _____

Store Address _____

Store City, State, Zip _____

Date Purchased _____

Complete the grid below for boxes purchased on the above date.

List each box separately.

Box Number	Test Kit Brand	Number of Tests in the Box	Total Paid
1			
2			
3			
4			
5			
6			
7			
8			

Note 1: The original store receipt and the original UPC proof of purchase panel from the OTC COVID-19 test box MUST be included with this Reimbursement Request Form in order to be processed. **Photocopies or pictures of receipts or UPC proof of purchase panels are not acceptable.**

Note 2: Reimbursement will be in the amount of $12 per test or purchase price of the test, whichever is less.

Note 3: Limit 8 tests per member per calendar month.

Mail this completed form along with the original receipt and box barcodes to:
Health Alliance Medical Plans, Inc.
Attention: Claims Department
P.O. Box 6003
Champaign, IL 61822

Questions?

If you have questions please call the number on the back of your ID card.