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 (POLICY HOLDER)

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 (Enter the name of the person the claim is for)	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH

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

❑ **SUBSCRIBER** (POLICY HOLDER) ❑ **SPOUSE** (OF POLICY HOLDER) ❑ **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:
- 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:** __________

Save the completed form as a PDF, and email it to COVIDTestClaims@BCBSMA.com. Include only one form per email. If submitting multiple forms, email them separately.

OR

Mail it to Blue Cross Blue Shield of Massachusetts, Local Claims Department, PO Box 986030, Boston, MA 02298.

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.
ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID card (TTY: **711**).
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: **711**).
ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: **711**).

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