THIS FORM APPLIES TO OVER-THE-COUNTER COVID-19 TEST KITS PURCHASED BEFORE MAY 11, 2023 ONLY

Over the Counter (OTC) COVID-19 Test Reimbursement Claim Form

MUTUAL HEALTH SERVICES™

Please note: This form is for COVID-19 over the counter (OTC) test kits **only** (visually read and results interpreted by you). This form **should not** be used to request reimbursement for specimen collection kits processed by a lab or other facility. Use our standard medical claim form instead.

To process your claim, the following information is needed:

1. This completed claim form
2. The UPC bar code found on the packaging for each box
3. Original receipt for each test
4. Attach additional claim forms if needed

Please retain a copy of your receipt(s) and UPC bar code(s) for your records.

Reminders: Costs for shipping and handling will not be included. Reimbursement will be directed to the policyholder. Items purchased through a Flexible Spending Account or Health Savings Account (FSA or HSA) are not reimbursable. Per FDA guidelines, the Test is authorized for individuals two years of age and older.

Policyholder Information		
Last Name	First Name	Birth Date (Month/Day/Year)
Address		
City	State	Zip Code
Policyholder ID# (refer to ID Card)	Phone Number	Email Address

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Patient and Test Purchase Information

Please Note: A total of 8 tests will be allowed per patient per 30 days. Some test kits may contain multiple tests in a box. Please indicate how many tests per box below.

Patient# 1: Last Name	Patient First Name	Birth Date (Month/Day/Year)

Patient Relationship to policyholder (Check one box): ☐ Self ☐ Spouse ☐ Child ☐ Other Dependent

Brand name of test(s) purchased for this patient (e.g., BinaxNow, Quickvue, etc.)	Number of boxes	Number of tests per box	Date(s) of purchase	Amount Paid
				$
				$
			Total	$

Patient# 2: Last Name	Patient First Name	Birth Date (Month/Day/Year)

Patient Relationship to policyholder (Check one box): ☐ Self ☐ Spouse ☐ Child ☐ Other Dependent

Brand name of test(s) purchased for this patient (e.g., BinaxNow, Quickvue, etc.)	Number of boxes	Number of tests per box	Date(s) of purchase	Amount Paid
				$
				$
			Total	$

Patient# 3: Last Name	Patient First Name	Birth Date (Month/Day/Year)

Patient Relationship to policyholder (Check one box): ☐ Self ☐ Spouse ☐ Child ☐ Other Dependent

Brand name of test(s) purchased for this patient (e.g., BinaxNow, Quickvue, etc.)	Number of boxes	Number of tests per box	Date(s) of purchase	Amount Paid
				$
				$
			Total	$

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Policyholder Certification and Signature

By checking the boxes below, you are certifying that the information submitted on this claim form is true and accurate. All boxes must be checked, and the Policyholder's Signature must be provided for the claim to be processed:

- ☐ The test(s) submitted were purchased for me or my covered dependents for our personal use and will not be given or sold to a third party.
- ☐ The test(s) submitted are not being used for employer-required or travel related testing.
- ☐ I have not used my FSA or HSA funds to purchase these test(s).

Note: Any person who, with intent to defraud or knowingly is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Signature: _____ **Date:** _____

Attach original UPC(s) and receipt(s) for each box. Retain a copy for your records.

Please send the completed form and requested documentation to:

Mutual Health Services, P.O. Box 6018 Cleveland Ohio 44101-1018