Caterpillar – COVID-19 At Home Test Drug Claim Form

Instructions for completing COVID-19 At Home Test Drug Claim Form:

This form is for COVID-19 At Home Tests purchased on or after Mar. 1, 2022. For test(s) purchased between Jan. 15 and Feb. 28, 2022, please contact your medical plan (UHC or BCBS).

Please complete all sections of the claim form below.

- Only one patient can be submitted per claim form.
- Copies of cash register receipts (or proof of payment) must be included with submitted claim form.
- Proof of purchase must clearly provide the following information for each expense:
  - Name of pharmacy or retailer
  - Date purchased
  - Amount paid out-of-pocket
  - Detailed description of purchased item (for example: Binaxnow, Flowflex, Carestart)
  - Quantity purchased
  - Cost of test(s)
- Please mail or fax the completed form and accompanying receipts to:

  Magellan Health Services
  Attn: Claims Dept.
  11013 W. Broad St., Ste #500
  Glen Allen, VA 23060
  OR Fax: 1-800-424-7644
- Please retain a copy for your personal files.
- Reimbursement is not guaranteed. Claims are subject to limitations, exclusions and provisions of the plan in accordance with the Families First Coronavirus Response Act (FFCRA) and Coronavirus Aid, Relief, and Economic Security (CARES) Act.
- If you have any questions, please call Customer Service at 1-877-228-7909.

1. Policyholder or Insured Name (First, Middle, Last) _____

   Address _____

   City _____ State _____ Zip Code _____
2. Policyholder or insured ID No. (as shown on ID Card) _____
3. Patient's Name (First, Middle, Last) _____
4. Patient's Birth Date _____
5. Patient's Relationship to Policyholder: ☐ Self ☐ Spouse ☐ Dependent ☐ Other _____
6. OTC COVID-19 antigen at home self-test purchased (enter all that apply). For example, if you purchased two (2) boxes/kits of the Abbott BinaxNow test, enter the quantity purchased as two (2). The COVID-19 at home test must have an Emergency Use Authorization by the U.S. Food and Drug Administration (FDA) or be FDA-approved.

Name of COVID-19 OTC at-home test	Tests per Box	# Boxes Purchased
☐ Abbott BinaxNow COVID-19 Antigen Self-Test	2	
☐ Access Bio CareStart Antigen Home Test	2	
☐ Flowflex COVID-19 Antigen Home Test	1	
☐ iHealth COVID-19 Antigen Rapid Test	2	
☐ InteliSwab COVID-19 Rapid Test	2	
☐ Quidel QuickVue At-Home COVID-19 Test	2	
☐ On/Go At-Home COVID-19 Test	2	
☐ Other Name of test _____		

I certify that my COVID-19 At Home Test(s) were purchased for personal use, are not for employment purposes, have not been (and will not be) reimbursed by another source, and are not for resale. I certify that the information on this claim form is correct to the best of my knowledge. I authorize the release of any medical information pertaining to this claim to Magellan Rx Management, its agents or representatives.

Signature _____ **Date** _____

Please Note: Signature and accompanying receipt(s) are required. Missing or incomplete information may result in delayed reimbursement.