

## **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)					
	R ON SUBSCRIBER ID CARD first 3 characters)	SUBSCRIBER'S LAST NA	ME	FIRST NAME	MIDDLE INITIAL
ADDRESS	- NUMBER AND STREET			CITY	
STATE	ZIP CODE	EMPLOYER'S NAME			
CLAIM INFORMATION					
	'S LAST NAME e name of the person the cla	im is for)	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH
CLAIM IS FOR (CHOOSE ONE AND COLOR IN THE ENTIRE BOX):					
□ SUBSCI	RIBER (POLICY HOLDER)	☐ SPOUSE (OF POLICY HOLDER)	□ EX-SPOU	JSE DEPENDENT (U	P 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 BURCHASE  DATE OF BURCHASE  DATE OF BURCHASE					
O/AV		DATE OF		BRAND NAMI	E
1		DATE OF	AMOUNT PAID	BRAND NAMI	E
		DATE OF		BRAND NAMI	E
1		DATE OF		BRAND NAMI	E
1 2		DATE OF		BRAND NAMI	E
1 2 3		DATE OF		BRAND NAMI	E
1 2 3 4		DATE OF		BRAND NAMI	E
1 2 3 4 5		DATE OF		BRAND NAMI	E
1 2 3 4 5 6		DATE OF		BRAND NAMI	E
1 2 3 4 5 6 7 8 Important I • Keep copie • Blue Cross • Reimburse Certification I certify that I understand purchases t	nformation: es of receipts in case we request s Blue Shield of Massachusetts wi ement is sent to the member's ad in and Authorization (This form in t the information provided in supp d that Blue Cross Blue Shield of M	them from you.  Il make a reimbursement decision within 30 cdress on file with Blue Cross. Reimbursement	alendar days of receiving may be considered taxa ct, and that I have not preor a reimbursement deci	g a completed request form. able income, so you should consult y eviously submitted for these purcha ision. I authorize the release of any ir	our tax advisor. uses. users. users.
1 2 3 4 5 6 7 8 Important II • Keep copi • Blue Cross • Reimburse Certificatio I certify that I understand purchases t purposes, at	nformation: es of receipts in case we request s Blue Shield of Massachusetts wi ement is sent to the member's ad in and Authorization (This form in t the information provided in sup; t that Blue Cross Blue Shield of M o Blue Cross Blue Shield of Massac	them from you.  Il make a reimbursement decision within 30 c dress on file with Blue Cross. Reimbursement nust be signed and dated below.)  Foot of this submission is complete and correct assachusetts may require proof of payment frichusetts. By submitting this claim for reimbursement.	alendar days of receiving may be considered taxa ct, and that I have not preor a reimbursement deci	g a completed request form. able income, so you should consult y eviously submitted for these purcha ision. I authorize the release of any ir	our tax advisor. ises. information about e, not for employment

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. ATTENTON: 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 hable 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). ATENCIÓN: 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).