



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 between January 15, 2022 and May 11, 2023. Submit a separate form for each covered member, including dependents. If your employer elects to continue this coverage, you may still be eligible to receive these benefits and can submit for reimbursements using this form for purchases made on or after May 12, 2023. If you have questions, call Member Service at the number on your ID card.

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):				
<input type="checkbox"/> SUBSCRIBER (POLICY HOLDER)	<input type="checkbox"/> SPOUSE (OF POLICY HOLDER)	<input type="checkbox"/> EX-SPOUSE	<input type="checkbox"/> DEPENDENT (UP TO AGE 26)	
<input type="checkbox"/> 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 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.