PRESBYTERIAN

Presbyterian Health Plan, Inc.

Centennial Care

At-Home Over-the-Counter (OTC) COVID-19 Test Kits Reimbursement Form

If you would like help submitting this claim form, please contact the Presbyterian Pharmacy Services team by email at **askpharmacy@phs.org**. You may also call the number on the back of your member ID card or one of the following numbers (follow the prompts for pharmacy):

Phone: (505) 923-5200 **Toll free:** 1-888-977-2333 **TTY Users:** 711

Presbyterian Customer Service Center hours: Monday through Friday, 8 a.m. to 5 p.m.

Please submit claim forms to:
Presbyterian Health Plan, Inc. Attention: Pharmacy Services P.O. Box 27489 Albuquerque, NM 87125-7489

Si usted desea recibir informacion en español sobre el contenido de este documento, sirvase llamar a nuestro Centro de Atencion a los Clientes al (505) 923-5200 o al 1-888-977-2333, de lunes a viernes, de las 8 de la mañana a las 5 de la tarde oa la línea telefónica. TTY para personas con problemas auditivos al 1-877-298-7407.

CLAIM FILING INSTRUCTIONS

All requests for reimbursement must include the **Pharmacy Prescription pamphlet** and/or an **original cash register receipt**. This should include the at-home OTC COVID-19 test purchase details.

Your request must include all the items listed below:

- ☐ Patient's name
- ☐ Date of Birth
- ☐ Fill date
- ☐ Name of Pharmacist/Location where purchase was made
- ☐ Drug name and NDC (National Drug Code)
- ☐ Retailer/Pharmacy Name and Phone number
- ☐ Proof of purchase/payment summary (cash register receipt/online order detail)
- ☐ Quantity dispensed
- ☐ Amount of each prescription, including tax

SECTION 1: MEMBER INFORMATION

The member or primary policy holder must complete this section.

First Name, MI, Last Name	Gender ☐ M ☐ F	DOB (m/d/yy)	Member ID #: Group # (if applicable):

Address (No PO Boxes)	City	State	County	ZIP Code

Home Phone	Work/Message Phone	Email Address

SECTION 2: PATIENT INFORMATION

Please complete for member, legal spouse or dependent child(ren) who are the patient for this claim. Dependent child(ren) must meet the terms of eligibility under your plan.

Name (First, MI, Last)	**Relation**			**Gender**	**DOB** (m/d/yy)
	☐ Member	☐ Spouse	☐ Dependent Child	☐M ☐F	
	☐ Member	☐ Spouse	☐ Dependent Child	☐M ☐F	
	☐ Member	☐ Spouse	☐ Dependent Child	☐M ☐F	

SECTION 3: AT-HOME OTC COVID-19 TEST KIT COVERAGE

- Reimbursement is limited to eight at-home OTC COVID-19 tests per member, per 30 days.
- Reimbursement is limited to a maximum of $12.00 per test (including tax) when purchased at a store or online retailer or if you are charged for a test outside of the Presbyterian preferred network. For example, if you bought a test kit that contained two tests, the reimbursement would be $24.00 or the total cost of the test, whichever is lower.
- Reimbursement is limited to at-home OTC COVID-19 test kits which must be purchased by the member for personal use, has not and will not be reimbursed by another source, and is not for resale.

SECTION 4: PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

I authorize the release of any medical information necessary to process this claim. All legal-age members or the parent/legal guardian of a minor child member must sign and date this claim form. By signing this form, I attest that the products submitted for reimbursement were used for me or my family.

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE REIMBURSEMENT IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

Name of Member (*please print*) (or Legal Guardian)	**Signature of Member** (*required*) (or Legal Guardian)	**Today's Date**
Name of Member's Spouse If submitting claim (*print*)	**Signature of Member's Spouse** If submitting claim (*required*)	**Today's Date**