HealthComp

OTC COVID TEST CLAIM FORM

You can complete this form electronically on HCOnline at: https://hconline.healthcomp.com
Instructions: 1. Click the link above to login/sign up 2. Click "Forms" 3. Click "Covid test"

1. Your Policy and/or Group number(s)

2. Name and address of Plan Sponsor or Employer

MEMBER INFORMATION

3. Name of Primary Subscriber *(insured)*	☐ Male ☐ Female	Date of Birth	4. Primary Subscriber Medical ID or Social Security number
5. Street Address	City	State	Zip Code
6. Name of Spouse or Domestic Partner	Date of Birth		Social Security number

INFORMATION ABOUT THE TEST KITS YOU PURCHASED

7. The test(s) were purchases for (Check only one): ☐ Primary Subscriber ☐ Spouse or Domestic Partner ☐ Child

8. How many test kits did you purchase for this person:

Number of test kits containing a single test: _____

Number of test kits containing two tests: _____

9. Tests must be FDA-approved or authorized by the FDA under Emergency Use Authorization (EUA). You can find this information on the box of the test kit.

Enter the manufacturer and name for each test kit below:

Manufacturer: _____ Name of test:_____

Manufacturer: _____ Name of test:_____

Manufacturer: _____ Name of test:_____

Manufacturer: _____ Name of test:_____

Attach the receipts that reflect the date of purchase and the price for each test kit.

IF THE CLAIM IS FOR YOUR DEPENDENT, COMPLETE THIS SECTION

10. Name of your dependent	☐ Male ☐ Female	Date of Birth	Social Security Number of dependent

IMPORTANT – PLEASE COMPLETE THE ATTESTATION BELOW

11. **The undersigned participant certifies that the test kits purchased were NOT for employment purposes.**

The undersigned participant certifies that the test kits were NOT purchased for resale.

The undersigned participant in the Medical Plan certifies that all expenses for which reimbursement is claimed by submission of this form, were purchased while the undersigned was covered under the Employer's Medical Plan and that such expenses have not been reimbursed, or are not reimbursable, by any other entity, health plan or flexible spending account. The undersigned understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which reimbursement is claimed as a proper expense under the Plan, the undersigned may be liable for the payment of all related taxes including federal, state or city income tax on amounts paid by the Plan which relate to such expense.

_____

Signed (Patient or Parent if Minor) **Date**

Need to mail or fax? Mail to: P.O. BOX 45018, FRESNO, CA 93718-5018 or Fax to: (559) 499-2464