# Member Reimbursement Form for Over the Counter COVID-19 Tests

**ONE FORM PER FAMILY**

KAISER PERMANENTE®

Please print clearly, complete all sections and sign. Retain copy for personal records.

NOTE: In order to be reimbursed, the submission needs to include:

- The itemized purchase receipt documenting the name of the test, the date of purchase, the price, the quantity of tests and some evidence of your payment
- A picture or cut out of the QR or UPC code from the testing package

| Subscriber Name | Subscriber I.D.#: |
|---|---|
| Subscriber Address | |

Type of insurance: ☐ HMO ☐ Options ☐ PPO ☐ Medicare

| First Name | Last Name | Member I.D. # | How many tests per member? |
|---|---|---|---|
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**Custodial Parent Information:** This must be completed for reimbursement requests from a Parent for a child (under the age of 18) when the requesting Parent meets both of the following requirements:

1. Parent is not enrolled in the same Kaiser Permanente plan as the child
2. Parent does not reside in the same household as the subscriber under the child's Kaiser Permanente plan
3. The requesting parent will need to include a copy of the divorce decree or parenting plan indicating the custodial parent if not the subscriber.

Legal Custodian's Name: _____

Legal Custodian's Contact Phone #: _____

Custodian Requesting Reimbursement Name: _____

Custodian Requesting Reimbursement Contact Phone #: _____

Address payment is to be mailed to: _____

**If your child is covered under two or more health plans, state law determines the order of benefits for processing claims.**



CL0000006-01-22

1. Tests ordered online must have already shipped (not pending, not in process). Please do not seek request reimbursement until your tests have shipped. Has your test shipped? ☐ Y ☐ N
2. Did you purchase the test before January 15, 2022? ☐ Y ☐ N
   - If yes, you are only required to include evidence of prescription or provider involvement and sign the attestation at the end of the form.
   - If no, continue to fill out the remaining items.
3. Was the test ordered by a physician or was there physician oversight or involvement? ☐ Y ☐ N
4. Was the test Authorized, Approved or Cleared by the Food and Drug Administration (FDA)? ☐ Y ☐ N
   - Emergency Use Approval is permitted.
5. Was the test required for employment? ☐ Y ☐ N
6. One purchased box or kit may have multiple tests within. For example, one box may have two tests in it. How many total tests were purchased? _____
7. Where were the results determined? ☐ Home ☐ Lab

Signature is required:

I certify that my At Home Over the Counter COVID test(s) were purchased for personal use, is not for employment purposes unless permitted by applicable state law, has not and will not be reimbursed by another source, and is not for resale.

**Signature:** _____ **Date:** _____

Reimbursement requests will be processed within 60 days of receipt.

Submit all documents to:

**Claims Processing**
**Kaiser Permanente**
**P.O. Box 30766**
**Salt Lake City, UT 84130-0766**