TUFTS Health Plan

Tufts Health Plan Medicare Advantage (HMO) COVID-19 At-Home Test Member Reimbursement Form

For purchases made on or after February 1, 2022, through the end of the Federal Public Health Emergency or December 31, 2022, whichever is earlier, Tufts Health Plan Medicare Advantage HMO plan members can complete this form to be reimbursed for over-the-counter COVID-19 at-home tests. Only at-home tests that are approved by or have an Emergency Use Authorization (EUA) from the FDA are eligible for reimbursement. Check the list of FDA/EUA authorized tests on our website at **thpmp.org/COVID-19-testing**.

Please note: This reimbursement form is for Tufts Health Plan Medicare Advantage HMO plan members only.

Get Started Now

1. Complete one form per member per claim.
2. For individualized diagnosis or treatment of COVID-19 (not for resale), and not for employment purposes. Reimbursement is permitted for up to eight over-the-counter COVID-19 at-home tests per member per calendar month, when administered without an individualized clinical assessment.
3. Submit the following to the address listed at the end of this form (any missing information may result in delay or denial of the reimbursement):
   a. This completed and signed reimbursement form.
   b. Proof of payment for the COVID-19 at-home tests being requested for reimbursement.
4. Reimbursement will be sent to the Plan subscriber at the address the Plan has on record. To view your address of record, please log on to **thpmp.org/login** or call Member Services at **1-800-701-9000 (TTY: 711)**.
5. **Cost of shipping, handling, and sales tax are not included in reimbursement.**

If a Member Reimbursement is being submitted by an Authorized Representative, please complete and include the Tufts Health Plan *Appointment of Personal Representative (AOR) Form*, or any legal documentation verifying personal representation, with your request. We require verification of the authority of a Personal Representative before the request can be processed. You can find the AOR Form on our website at **thpmp.org/tmp-aor-form**.

☐ **I am completing this form as an Authorized Representative to the subscriber.**

Member Information

By providing your contact information below, you agree to be contacted by us regarding your plan benefits and administration.

First name | Middle initial (optional) | Last name

Street address

Town/City | State | ZIP code

Member ID number (S + 8 digits + 01) | Date of birth | Phone number (optional)

At-Home Test Purchase Information

Please note that some test kits may contain multiple tests in a box. Please indicate the number of tests per box below.

Brand name of at-home test (e.g., iHealth, BinaxNOW, etc.)	Barcode number/UPC (12 digits, optional)	Number of boxes	Number of tests per box	Date(s) of purchase (MM/DD/YY)	Amount paid
					$
					$
					$
					$
					$
					$
					$
					$
				Total (excludes shipping, handling, and taxes)	$ 0.00

Find this code under the product's barcode:

Member Signature (Required)

I certify that the information on this form and all supporting documents enclosed is complete, accurate, and unaltered. I acknowledge tests purchased through resellers (e.g., eBay, Facebook Marketplace) are not eligible for reimbursement. I further attest that these at-home tests are for personal use, and intended for individualized diagnosis or treatment of COVID-19 (not for resale). I further attest that these tests have not been and will not be reimbursed by another source, and that I am not entitled to reimbursements for tests I did not pay for (e.g., free test kits from the state or federal government). Moreover, I attest that this request does not exceed coverage for more than eight (8) COVID-19 tests per member per calendar month, as described above, from Tufts Health Plan as a reimbursement or as coverage through an in-network pharmacy.

I understand that reimbursement payment will be made to the Plan subscriber and will contain information about the service (e.g., date, COVID-19 test brand name). I also understand that Tufts Health Plan may request any additional information it deems necessary to verify that the tests were received for the covered purpose and payment was made.

Signature _____

Date (MM/DD/YY) _____

Let's Double Check

- ☐ I have completed and signed this form in its entirety.
- ☐ I have enclosed proof of payment.
- ☐ I understand that most completed reimbursement requests are processed within 60 calendar days.
- ☐ I have kept copies of my original receipts for my records.

Instructions

If you purchased your test(s) **between February 1, 2022–February 14, 2022**, mail this form and proof of payment to:

Tufts Health Plan
P.O. Box 214
Canton, MA 02021-0214

If you purchased your test(s) **on or after February 15, 2022**, mail this form and proof of payment to:

CVS Caremark Medicare Claims Processing
P.O. Box 52066
Phoenix, Arizona 85072-2066

If you have any questions, please visit **thpmp.org/COVID-19-testing** or contact Member Services at **1-800-701-9000 (TTY: 711)**. Our representatives are available to assist you 8 a.m.–8 p.m., 7 days a week (Mon.–Fri. from Apr. 1–Sept. 30).

For internal use only
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