

## Over-the-counter (OTC) At-home COVID-19 Test Reimbursement Form

This form is to request reimbursement for U.S. Food and Drug Administration (FDA) authorized over-the-counter (OTC), at-home, COVID-19 tests that may be covered under your medical plan purchased on or after Jan. 15, 2022.

- This form is for OTC COVID-19 tests purchased by you.
- Print your responses in black or blue ink. You can also complete the form using a computer to print and mail us the completed form.
- Include proof of payment (such as a paid receipt) that includes the name of the test along with this completed form. If we don't receive the required information, your request will not be processed.
- Send the completed form and proof of payment to New York City Employees PPO (NYCE PPO) plan, Transition of Care, P.O. Box 21534, Eagan, MN 55121.

### Member information

Full name \_\_\_\_\_

Member ID \_\_\_\_\_ Plan/group # **76-417151**

Date of birth     /     /      
MM DD YYYY

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Is this a new address?      Yes      No

Phone number     -     -    

Email address \_\_\_\_\_

### Information about your OTC COVID-19 test

Enter how many individual tests were purchased? \_\_\_\_\_

**Note:** Many COVID-19 tests are sold as a 2-pack. For each 2-pack, the total number of individual tests purchased would equal 2.

Name of the FDA authorized test purchased (e.g., BinaxNOW, QuickVue, Intelliswab, etc.) \_\_\_\_\_

Amount you paid for the COVID-19 OTC, at-home test(s) including any applicable sales tax: \$ \_\_\_\_\_

Purchase date(s)     /     /      
MM DD YYYY

## Member signature

Signature \_\_\_\_\_

Date     /     /      
MM DD YY

**When I sign above, I am stating that the information above is correct. Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.**

## Ready to send the completed form?

### Before mailing your form, make sure you:

- Complete and sign the form
- Include proof of payment, such as a paid receipt
- Keep a copy of everything you send us

Please send the completed form and proof of payment to Transition of Care, P.O. Box 21534, Eagan, MN 55121.



### Questions? We're here to help.

If you have any questions, please call Member Services at **212-501-4444** (TTY 711).