COX HEALTHPLANS
CoxHealth
THINKING HEALTH FORWARD

COVID-19 FDA AUTHORIZED OVER-THE-COUNTER TEST MEMBER REIMBURSEMENT FORM

(Please note: Authorized U.S. Food and Drug Administration (FDA) tests are limited to 8 per Member per Month. Reimbursement limited up to $12 per at-home over-the-counter (OTC) test. Form will need to be submitted for each member. Reimbursement can take up to 45 business days and are processed in order which they are received. Form needs to be submitted within 30 days of purchase to be considered timely for reimbursement.)

Member Name:
Member ID#:
Member DOB:
Contract Holder Name *(If different than Member Name)*:
Contract Holder ID#:
Date Purchased:
Location Purchased:
***Reason for Test *(REQUIRED)*:** □ **Exposure** □ **Employment** □ **Symptoms** □ **Travel** □ **Other:**
Number of Tests Purchased *(limit 8 per member per month)*:
Name of Test Purchased:
***Items Attached with Form *(BOTH REQUIRED)*:** *Example:* □ **UPC Label** *(original physical product label must be included)* □ **Receipt** *(showing date of purchase and location for each test)* 
ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD. I VERIFY THAT ALL INFORMATION CONTAINED IN THIS FORM IS TRUE, CORRECT, AND COMPLETE TO THE BEST OF MY KNOWLEDGE. IN ORDER TO PROCESS A CLAIM FOR BENEFITS I HEREBY AUTHORIZE ALL INDIVIDUALS OR INSTITUTIONS HAVING INFORMATION AS TO THE CARE, ADVICE, TREATMENT, DIAGNOSIS, OR PROGNOSIS OF ANY PHYSICAL OR MENTAL CONDITION, OR THE FINANCIAL AND EMPLOYMENT STATUS, OR THE PATIENT, EMPLOYEE, OR NAMED BELOW, TO PROVIDE THIS INFORMATION TO COX HEALTHPLANS OR ANY AGENT OR INDEPENDENT ADMINISTRATOR ACTING ON ITS BEHALF (INCLUDING RECORDS). I UNDERSTAND THAT I HAVE THE RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION UPON REQUEST. A COPY OF THIS SHALL BE AS VALID AS THE ORIGINAL.

DATE:	**SIGNATURE OF MEMBER OR AUTHORIZED REPRESENTATIVE:**

**Form needs to be completed in its entirety, including required items to receive reimbursement.*

Send form to:
Cox HealthPlans, P.O. Box 5750, Springfield, MO 65801-5750 ATTN: FINANCE

INTERNAL ONLY	
DATE FORM RECEIVED:	BY: