McLaren HEALTH ADVANTAGE

McLaren HEALTH PLAN COMMUNITY

COVID Test Direct Member Reimbursement Form

Please complete the following information to get reimbursed for COVID-19 tests that you paid for out-of-pocket.

Important Information:

- Only FDA-authorized tests are eligible for reimbursement.
- Tests purchased before Jan. 15, 2022 are not eligible for reimbursement unless ordered by your health care provider.
- Proof of payment MUST be included with this form. Please provide
  - An original paid receipt that includes the name of the test
  - UPC code from the package
  - Date of purchase
- Limit of 8 tests allowed for reimbursement per member per month
- Test for employment purposes are not eligible for reimbursement

Complete one request per person.

Member Name:_____Member ID: _____

Subscriber Name:_____Phone Number: _____

Address: _____
Street City State ZIP

Name of the FDA-Authorized Test and Manufacturer:_____

UPC Code:_____

Place of Purchase (name of pharmacy): _____

Number of Tests Purchased: _____

If Multiple Tests, Number of Tests per Box: _____

Reimbursement Amount Requested: _____

By signing and submitting this form, I attest the information I provided is accurate and complete. I Also state the tests are not being used for employment purposes. Knowingly filing false, incomplete or misleading information may be subject to criminal or civil penalties.

Signature:_____Date: _____

Please mail, fax or email completed form along with proof of payment to:

MedImpact Healthcare Systems, Inc.
PO Box 509098
San Diego, CA 92150-9098
Fax: 858-549-1569
Email: Claims@Medimpact.com