MediExcel HEALTH PLAN

At-Home COVID-19 Tests

Instructions for submitting a reimbursement request from MediExcel Health Plan for the cost of FDA approved at-home COVID-19 tests. Effective January 15, 2022.

You will need to complete the following required steps:

1. You must be an active MediExcel Health Plan Member on the date of purchase.
2. Complete one reimbursement form per member.
3. A complete separate form is required for each enrolled member.
4. If the member is under 18 years old, the form must be signed by the parent or guardian enrolled in MediExcel Health Plan.
5. Include **itemized receipt** dated January 15th or later.
6. Submit the FDA approved brand name of the at-home COVID-19 test.
7. Include the Universal Product Code (UPC) from the box. The UPC code will be underneath the bar code and is typically a 12-digit number.

Important Notes - Please Read

You will be reimbursed the purchase price up to $12.00 USD. A maximum of eight tests per month are eligible. At-Home tests submitted for reimbursement cannot be used for employment purposes.

MediExcel Health Plan is licensed to cover emergency and urgent care in the U.S. We are awaiting regulatory guidance which may impact our future ability to cover At-Home COVID-19 Tests purchased in the U.S.

Incomplete forms or missing information may result in a delay or non-payment of your request. A completed reimbursement form must be submitted within 30 days of purchase. Please keep copies of all items sent to MediExcel Health Plan and allow 45 days from receipt of complete documentation for reimbursement.

Mail form with required document to:

MediExcel Health Plan
Attention Claims Department
750 Medical Center Ct., Suite 2
Chula Vista, CA 91911

For questions:
Contact our Claims Department at (619) 421-1659 x 2030, or by e-mail at claims@mediexcel.com.

At-Home COVID-19 Test Reimbursement Form

INSTRUCTIONS TO REQUEST REIMBURSEMENT FOR AT-HOME COVID-19 TESTS

1. You must be an active MediExcel Health Plan Member on the date of purchase.
2. Complete one reimbursement form per member.
3. A complete separate form is required for each enrolled member.
4. If the member is under 18 years old, the form must be signed by the parent or guardian enrolled in MediExcel Health Plan.
5. Include **itemized receipt** dated January 15th or later.
6. Submit the FDA approved brand name of the at-home COVID-19 test.
7. Include the Universal Product Code (UPC) from the box. Typically found underneath the bar code and is a 12-digit number.

You will be reimbursed the purchase price up to $12.00 USD. A maximum of eight tests per month are eligible. At-Home tests submitted for reimbursement cannot be used for employment purposes.

Incomplete forms or missing information may result in a delay or non-payment of your request. A completed reimbursement form must be submitted within 30 days of purchase. Please keep copies of all items sent to MediExcel Health Plan and allow 45 days from receipt of complete documentation for reimbursement.

Mail form with required document to **MediExcel Health Plan, Attention Claims Department, 750 Medical Center Ct., Suite 2, Chula Vista, CA 91911**.

MEMBER INFORMATION

Last Name	First Name	Member ID #

Street Address	City	State	Zip Code

Telephone Number or E-mail Address

PARENT/GUARDIAN – COMPLETE ONLY IF THE MEMBER IS UNDER 18 YEARS OF AGE

Last Name	First Name	Member ID #

RETAILER/PRODUCT INFORMATION

Retailer Name	Date of Purchase	Amount Paid to Retailer for COVID-19 Test (s)

Retailer Address

Brand name of the at-home COVID-19 test (s) purchased	Universal Product Code (UPC) from the box. Typically, a 12-digit number.

CERTIFICATION STATEMENT – READ, SIGN AND DATE

I attest that the COVID-19 tests for which I am requesting reimbursement were purchased for my personal use, were not purchased for employment purposes, have not been (*and will not be*) reimbursed by another source, and have not been (*nor will be*) given or sold to another individual or entity. I certify that the above information is true, and the attached material is correct and unaltered and that the expenses were incurred by the member named above. I understand all documents submitted become the property of MediExcel Health Plan and will not be returned. I understand that if I submit false receipts or fraudulently altered documents, I may be disenrolled from MediExcel Health Plan and / or subject to civil or criminal penalties. I authorize the release of any information needed to review or process this request. **I understand that the At-Home COVID-19 Test Reimbursement Program may be terminated by MediExcel Health Plan at any time**. **California Residents**: For your protection, California law requires the following to appear on/with this form. Any person who knowingly presents a false or fraudulent claim for the payment of a reimbursement is guilty of a crime and may be subject to fines and confinement in state prison.

_______________________________________ Patient Signature (or of Parent/Guardian if Patient is a Child)

_______________________ Date

MediExcel Health Plan Use Only	Date Processed:	Processed By:	Approved By:

Form B57AHT 012722 NRM