At-Home COVID Test Reimbursement Form

P.O. Box 709718
Sandy, UT 84070-971
(844) 234-4472

Thank you for choosing MotivHealth Insurance Company for your health insurance coverage. Please review the filing instructions for helpful information regarding how to complete your Over the Counter (OTC) COVID-19 test claim/reimbursement so that it will process quickly and accurately. Contact customer service toll-free at 844-234-4472 if you have any questions, or communicate with a live Personal Health Assistant (PHA) team on motivhealth.com. We are happy to serve you.

ATTESTATION:

I swear under penalty of perjury, that the OTC COVID-19 test was purchased by the Member, a beneficiary, or dependent for personal use, not for employment purposes, not for back to school purposes, has not been (and will not be) reimbursed by another source, including other insurance(s) and will not be resold. I understand that submitting fraudulent claims is a crime and may lead to the termination of my insurance through MotivHealth. (Utah Code § 76-8-502). I understand that violating the terms of this reimbursement form may lead to the repayment of all OTC COVID-19 tests as well as any collection fees associated with the recovery of fraudulent claims. I attest that I will submit no more than eight (8) OTC COVID-19 test for reimbursement per member per month to MotivHealth.

INSTRUCTIONS FOR FILING A CLAIM/REIMBURSEMENT

IMPORTANT:

- You only need to fill out this form if your health care professional isn't filing the claim or reimbursement for you. Your health care professional can still file the claim for you if they are out-of-network with your policy, however, they are not required to do so.
- Payment is made directly to contracting health care professionals. We only send payment to you when the OTC COVID test is not purchased through the pharmacy or is purchased at a non-designated pharmacy.
- If you have Medicare or other insurance coverage that is not already on file with MotivHealth Insurance Company, or if it has changed or terminated, please call us at 844-234-4472 to update your account to ensure your claim processes correctly and timely.
- All Members and their dependents are permitted to purchase and receive reimbursement from MotivHealth for up to eight (8) OTC COVID-19 tests per individual under the plan per month. This does not prohibit the Member from purchasing any additional test at their own cost or from any other source.
- Members who visit MotivHealth's designated OTC COVID-19 test vendors/pharmacies are permitted to be reimbursed one hundred percent (100%) of their out of pocket cost for OTC test. Any test purchased through a non-designated pharmacy/vendor will only be reimbursed up to twelve dollars ($12) per test regardless of the cost of the test.
- MotivHealth's designated pharmacies are listed on its website. www.MotivHealth.com.

FILING REQUIREMENTS:

- All claims for reimbursement must include the following:
- UPC code for the OTC COVID-19 test
- Receipt from the seller of the test. The receipt must document the date of purchase, the specific test and the price of the OTC COVID-19 test.
- Complete a separate claim form for each covered family member.
- If the patient has Medicare or other health insurance coverage, and that other insurance coverage is primary and MotivHealth is secondary, we need an Explanation of Benefits (EOB) for this service from the other insurance company when you send the completed form and itemized bill.

MEMBER INFORMATION				
Patient's Name (Last, First, M.I.)	Patient's Date of Birth (mm/dd/yyyy)			Patient's Sex ☐Male ☐ Female
Policy Holder's Name (Last, First, M.I.)		Patient's Relationship to Policyholder ☐ Self ☐Spouse ☐ Dependent		
Policyholder's Address	City	State	Zip	Telephone Number
Patient's ID Number	Employer Name			Group ID

Does the patient have coverage from any other health plan including Medicare?

☐ No. Please skip to Claim Details.

☐ Yes. Please attach the Explanation of Benefits (EOB) statement from the primary plan with this claim, and complete the following information

Note—Breakdown of charges and proof of payment is required.

CLAIM DETAILS		
Name of Pharmacy/Vendor	Address of Pharmacy/Vendor	Date of Purchase (mm/dd/yyyy)
Diagnosis (describe illness and symptoms requiring treatment):		Total Charges
Briefly describe (name brand, quantity, etc.) the OTC COVID test you purchased including UPC code:		
Have the charges been paid in full? ☐No. ☐Yes. Please attach receipt with UPC code of COVID test purchased.		

SIGNATURE		
To be accepted, this form must be fully completed (as appropriate to the claim being submitted) signed, and have an itemized bill attached.		
Patient's Signature (or legal guardian if patient cannot legally consent to services)	Relationship to Patient ☐Self ☐ Other	Date (mm/dd/yyyy)
Please Note: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefit.		

I certify that the above statements are correct and hereby authorize any physician, hospital, employer, union, insurance company, or prepayment organization to supply my employer and its agents any information required in connection with this claim. A photocopy of this authorization shall be as valid as the original.

Signature (Subscriber or Patient) **Date**

Thank you for choosing MotivHealth Insurance Company as your health plan administrator. We recommend that you make copies of everything that is submitted for your personal records.

1. If Submitting the Claim/Reimbursement by **Mail**, send to:

   MotivHealth Insurance Company
   P.O. Box 709718 Sandy,
   UT 84070-9718
   (844) 234-4472

2. If submitting by **Email**: PHA@motivhealth.com

3. If submitting by **Fax**: 844-533-1289