SHARP HEALTH PLAN

Member reimbursement request form

At-home COVID-19 tests

Purpose

The purpose of this form is to ask for a refund from Sharp Health Plan for the cost of FDA-approved at-home COVID-19 tests. Please note, reimbursement is not available for Medicare members.

Instructions

1. Reimbursement for approved charges will be mailed within 30 days of receipt of complete documentation. Maximum reimbursement is $12 per test.
2. Complete a separate form for each member who is requesting reimbursement. Only one form is needed per member.
3. The member who received the medical services must sign this form. If the member is under 18 years old, the form must be signed by the parent or guardian.
4. You will need the following information to complete this form.
   - The brand name of the at-home COVID-19 test that you purchased.
   - The Universal Product Code (UPC) from the box. The UPC will be underneath the bar code and is typically a 12-digit number.
5. Send this completed form and the following documents to Sharp Health Plan. Incomplete forms and missing information may result in a delay or non-payment of your request. Please keep copies of all items sent to Sharp Health Plan, including the following:
   - Proof of payment in the form of an itemized receipt.
   - If you are requesting a reimbursement for more than eight at-home tests per member per month, you will need to submit a physician's order stating that they were medically necessary.

Submit

Please submit the finished form and required documents online, by mail or by fax:

Online:
Log in or create a Sharp Health Plan online account at **sharphealthplan.com/login**
Select **Claims**, then **At-home COVID-19 test reimbursement**

By mail:
Attention: Claims Research
Sharp Health Plan
8520 Tech Way, Suite 200
San Diego, CA 92123

By fax:
Attention: Claims Research
1-858-636-2276

Member Information (Complete This Section for All Reimbursement Requests.)		
First name:	Last name:	Middle initial:
Sharp Health Plan Member ID#:	Phone number: ( )	Birth date (MM/DD/YY): / /
Home address (NOTE: P.O. Box is not allowed.):		
City:	State:	ZIP code:
Please include the brand name of the at-home COVID-19 test that you purchased, and the Universal Product Code (UPC) from the box. The UPC will be underneath the bar code and is typically a 12-digit number.		
Was test purchased as a result of an exposure at work? ☐ Yes ☐ No	If yes, give the date of the incident:	
Parent/Guardian (Complete This Section if the Member is Under 18.)		
First name:	Last name:	Middle initial:
Phone number: ( )		Birth date (MM/DD/YY): / /
Other Health Coverage (Complete This Section if You Have Other Health Coverage.)		
Other health plan name:	Health plan phone number: ( )	Effective date of other coverage (MM/DD/YY):
Policyholder's name:	Policyholder's ID#:	Policyholder's birth date (MM/DD/YY):
Type of coverage: ☐ Medical ☐ Dental ☐ Vision ☐ Other	Type of policy: ☐ Self only ☐ Self and spouse ☐ Family ☐ Other	

Certification Statement		
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 (and will not 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 patient named above. I understand all documents submitted become the property of Sharp Health Plan and will not be returned. I understand that if I submit false receipts or fraudulently altered documents, I may be disenrolled from Sharp Health Plan and/or subject to civil or criminal penalties. I authorize the release of any information needed to review or process this request.		
Member's name (Parent/Guardian if child):	Member's signature (Parent/Guardian if child):	Date (MM/DD/YY): / /

If you need assistance, we're here to help. You can call Customer Care at 1-858-499-8300 or toll-free at 1-800-359-2002, or email us at **customer.service@sharp.com.** We are available to assist you Monday through Friday, 8 a.m. to 6 p.m.

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call Sharp Health Plan right away at 1-858-499-8300 or 1-800-359-2002.

IMPORTANTE: ¿Puede leer esta carta? Si no le es posible, podemos ofrecerle ayuda para que alguien se la lea. Además, usted también puede obtener esta carta en su idioma. Para ayuda gratuita, por favor llame a Sharp Health Plan inmediatamente al 1-858-499-8300 o 1-800-359-2002.