



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 barcode 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. Open the menu and select **At-home COVID-19 test reimbursement form**.

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/YYYY): / /
Home address (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 barcode and is typically a 12-digit number.		
Was the 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/YYYY): / /
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/YYYY):
Policyholder's name:	Policyholder's ID#:	Policyholder's birth date (MM/DD/YYYY):
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/YYYY):

/ /



If you need assistance, we're here to help. Log in to your Sharp Health Plan online account at sharphealthplan.com/login to send Customer Care a secure message, call 1-858-499-8300 or call toll-free at 1-800-359-2002. 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.

Language Assistance Services

English

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-800-359-2002 (TTY:711).

Español (Spanish)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-359-2002 (TTY:711).

繁體中文 (Chinese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-359-2002 (TTY:711)。

Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-359-2002 (TTY:711).

Tagalog (Tagalog – Filipino):

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-359-2002 (TTY:711).

한국어 (Korean):

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-359-2002 (TTY:711) 번으로 전화해 주십시오.

Հայերեն (Armenian):

Ուշադրություն: Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-800-359-2002 (TTY (հեռատիպ)՝ 711).

(Farsi): فارسی

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما تماس بگیرد.
1-800-359-2002 (TTY:711) با. باشد می فراهم.

Русский (Russian):

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-359-2002 (телетайп: 711).

日本語 (Japanese):

注意事項:日本語を話される場合、無料の言語支援をご利用いただけます。1-800-359-2002 (TTY:711) まで、お電話にてご連絡ください。

ةيبرعلا (Arabic):

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم
1-800-359-2002 (رقم هاتف الصم والبكم: 711).

ਪੰਜਾਬੀ (Punjabi):

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵੱਲੋਂ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-359-2002 (TTY/TDD: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ខ្មែរ (Mon Khmer, Cambodian):

ប្រុងចិត្ត: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់អ្នក។ ចូរទូរស័ព្ទ 1-800-359-2002 (TTY:711)។

Hmoob (Hmong):

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-359-2002 (TTY:711).

हिंदी (Hindi):

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-359-2002 (TTY:711) पर कॉल करें। कॉल करें।

ภาษาไทย (Thai):

เรียน: ถ้านคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-359-2002 (TTY:711).