Chorus Community Health Plans
PO Box 106013 | Pittsburgh, PA 15230-6013
Toll free: 1-844-201-4677 | chorushealthplans.org

At Home Covid-19 Test Reimbursement Form

Use this form to request reimbursement for COVID-19 tests you have paid for out of your own pocket.

Member Information

MEMBER NAME (LAST, FIRST, MI) | DATE OF BIRTH | ☐F ☐M GENDER | MEMBER ID NO.

STREET | CITY | STATE | ZIP | DAYTIME PHONE

☐ PLEASE CHECK IF NEW ADDRESS:

PLAN NAME / PLAN TYPE | GROUP ID NO.

Test Information

PHARMACY/STORE NAME | DATE OF PURCHASE

PHARMACY/STORE ADDRESS, STREET | CITY | STATE | ZIP

NAME OF TEST(S)	NDC	UPC	QUANTITY OF TESTS PURCHASED	PRICE PER TEST
*IS THIS TEST FDA AUTHORIZED? ☐ YES ☐ NO				
*IS THIS TEST FDA AUTHORIZED? ☐ YES ☐ NO				

TOTAL COST

NDC: *The National Drug Code is a unique 3 segment 10- or 11-digit number that identifies the drug.*
UPC: *The Universal Product Code consists of 12 digits that are uniquely assigned to each trade item.*

Remember: a paper receipt is required for any reimbursement request and should be included with this form.

REASON FOR TEST (PLEASE SELECT ONE)

- ☐ I have (had) Covid-19 symptoms
- ☐ I was exposed to someone with Covid-19
- ☐ For work, school or travel
- ☐ Other:

Signature

I certify that all information provided is correct, that the receipts(s) submitted are for me, and I will not be reimbursed from another source.

MEMBER/GUARDIAN SIGNATURE | DATE

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Internal Reference: COR Member Form – COVID-19 Test Reimbursement Form (Rev. 2022.0121)

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Instructions for reimbursement for at-home COVID-19 tests for Chorus Community Health Plans members

Please complete this reimbursement form for anyone in your household who has purchased an FDA-authorized COVID-19 test.* Only tests purchased at a U.S. retail store or website on or after Jan. 15, 2022 are eligible for reimbursement. Tests submitted for work, school or travel may not be reimbursed. Tests that are paid using Flexible Spending Accounts (FSA) or Health Savings Accounts (HSA) are not eligible for reimbursement. This form is for Chorus Community Health Plans members only. Incomplete submissions may result in a claim denial.

*More information on FDA authorized tests here.

Please remember that only one reimbursement form per member ID number is allowed. If multiple family members are requesting reimbursement, a separate form must be submitted for each member.

Attach a legible copy of the receipt for the test(s) that clearly shows retailer purchase date, tests purchased, and paid amounts. Please note, a prescription may be required for certain tests if they require a provider or lab to read the results. If you ordered the test online, print and attach your electronic receipt. Be sure to keep a copy of your receipt.

Once the form is complete, mail with a copy of the receipt to:
Chorus Community Health Plans
PO Box 106013
Pittsburgh, PA 15230-6013

Please note that payment will be sent to the subscriber, who may not be the member. Limit of 8 tests per member per month.

Reimbursements may take up to 60 days. Please contact Customer Service if you have not received your reimbursement within that time frame.

Any person who knowingly and with intent to defraud any insurance company or other person who files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Please visit chorushealthplans.org to find a list of in-network pharmacies and community sites to obtain Covid-19 tests.

Internal Reference: COR Member Form – COVID-19 Test Reimbursement Form (Rev. 2022.0723)