Over the Counter (OTC) COVID-19 Test
Reimbursement Claim Form

MEDICAL MUTUAL®

Please note: This form is for COVID-19 over-the-counter (OTC) test kits **only** (visually read and results interpreted by you). This form **should not** be used to request reimbursement for specimen collection kits processed by a lab or other facility. Use our standard medical claim form instead.

To process your claim, we will need:

- This completed claim form
- The UPC bar code found on the packaging for each test
- Original receipt for each test

Attach additional claim forms if needed.

A total of 8 tests will be allowed per patient per 30 days.

Please retain a copy for your records. *Payment will be directed to the policyholder.*

One order of four free tests for your household is available at www.covidtests.gov, at no upfront cost to you.

Policyholder Information:

Medical Mutual ID #: _____

Name: _____
Last First

Address: _____

_____
City State Zip

Phone #: _____ Email: _____

☐ Please check this box if someone on this policy has coverage with a different insurance carrier.

Other Insured's Name: _____
Last First

Other Insured ID's #: _____

Other Insurance Plan Name: _____

Tests purchased for:

1. Patient Last Name | Patient First Name | Patient Birthdate (__ __/__ __/__ __ __ __)

Patient Relationship to policyholder (Check one box): ☐ Self ☐ Spouse ☐ Child ☐ Other Dependent

Name of the FDA authorized test(s) purchased: _____

Purchase Date(s) _____

Total charge for this patient: $_____ Number of tests you are submitting for this patient: _____

2. Patient Last Name | Patient First Name | Patient Birthdate (__ __/__ __/__ __ __ __)

Patient Relationship to policyholder (Check one box): ☐ Self ☐ Spouse ☐ Child ☐ Other Dependent

Name of the FDA authorized test(s) purchased: _____

Purchase Date(s) _____

Total charge for this patient: $_____ Number of tests you are submitting for this patient: _____

3. Patient Last Name | Patient First Name | Patient Birthdate (__ __/__ __/__ __ __ __)

Patient Relationship to policyholder (Check one box): ☐ Self ☐ Spouse ☐ Child ☐ Other Dependent

Name of the FDA authorized test(s) purchased: _____

Purchase Date(s) _____

Total charge for this patient: $_____ Number of tests you are submitting for this patient: _____

I certify the following:

- ☐ The test(s) submitted were purchased for me or my covered dependents for our personal use and will not be given or sold to a third party.
- ☐ The test(s) submitted are not being used for employer-required or travel related testing.
- ☐ I have not used my FSA or HSA funds to purchase these test(s).

Note: Any person who, with intent to defraud or knowingly is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Signature: _____ Date: _____

Attach original UPC and receipt(s) for the tests purchased in this box. Retain a copy for your records.

Please send the completed form and requested documentation to:

Medical Mutual, P.O. Box 6018 Cleveland Ohio 44101-1018