MEMBER REIMBURSEMENT FORM
For COVID-19 Over-the-Counter (OTC) Diagnostic Tests

To be reimbursed for OTC COVID-19 diagnostic tests, you must complete this form and include your receipts for each test. You can be reimbursed for up to eight (8) tests per member/per month. Please use one reimbursement form per member. Once we receive your COVID-19 OTC diagnostic test reimbursement form, please allow up to 30 days for your payment to reach you.

Member Full Name: _____

Member Date of Birth: _____ Member Health Plan I.D. Number: _____

Member Mailing Address: _____

_____

Date Test Purchased: _____ Number of Tests Purchased: _____

Name of Test Purchased: _____

Member Signature: _____

IMPORTANT: Receipts must be submitted with reimbursement request.

MAIL TO: Denver Health Medical Plan, Inc.
PO Box 6300
Columbia, MD 21045

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE 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. I VERIFY THAT ALL INFORMATION CONTAINED IN THIS FORM IS TRUE, CORRECT, AND COMPLETE TO THE BEST OF MY KNOWLEDGE. IN ORDER TO PROCESS A CLAIM FOR BENEFITS, I HEREBY AUTHORIZE ALL INDIVIDUALS OR INSTITUTIONS HAVING INFORMATION AS TO THE CARE, ADVICE, TREATMENT, DIAGNOSIS, OR PROGNOSIS OF ANY PHYSICAL OR MENTAL CONDITION, OR THE FINANCIAL AND EMPLOYMENT STATUS, OR THE PATIENT, EMPLOYEE, OR NAMED ABOVE, TO PROVIDE THIS INFORMATION TO DENVER HEALTH MEDICAL PLAN OR ANY AGENT OR INDEPENDENT ADMINISTRATOR ACTING ON ITS BEHALF (INCLUDING RECORDS). I UNDERSTAND THAT I HAVE THE RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION UPON REQUEST. A COPY OF THIS SHALL BE AS VALID AS THE ORIGINAL