Humana®

PUERTO RICO COMMERCIAL MEMBERS REIMBURSEMENT FORM
"OVER-THE-COUNTER" COVID-19 HOME TESTS
To be completed by the member

INSTRUCTIONS	1. Complete the application in its entirety. 2. If you are requesting reimbursement for more than one subscriber in the plan, fill out one application for each subscriber. 3. **Attach the receipt (required) documenting the date of purchase and the price of the test(s). Also, include a copy of the UPC code in the box of the test(s).** 4. Mail this request to the address on the back of your claim card or email: prclaimsreimbursements@humana.com.

1. **Contract or Subscriber number:** _____ - _____ - _____ - _____
2. **Group Number:** _____
3. **Member's name:** _____
4. **Mailing address: If you wish to notify a change of address other than the one in our records please add here:**

   _____

   _____
5. **Phone Number you can be reached at:** _____ - _____ - _____
6. **Name of provider:** _____
7. **Provider Type: ___Pharmacy ___Store ___ Other** - Specify: _____
8. **¿Any other primary health plan? ___Yes ___No; If Yes, Company**: _____

   Policy/ Contract Number: _____

	Name of test brand (from package)	Date Purchased	Place of Service	Service code	Diagnosis code	Number of test(s) per package (for brand)	Number of packages purchased (this Brand)	Total amount paid for the test(s) (this brand)
1st Test Brand			99	U0002	Z20.822			
2nd Test Brand			99	U0002	Z20.822			
3rd Test Brand			99	U0002	Z20.822			
4th Test Brand			99	U0002	Z20.822			

9. **I hereby certify that the at home over-the-counter diagnostic COVID-19 Test(s) purchased and for which I am submitting a request for reimbursement are for personal use only and are not for resale or for other individuals, other than me or my dependents in the health plan, to use. I also certify that the test(s) are not for employment screening or public health surveillance purposes and have not been (and will not be) reimbursed by another source. I understand that any person who knowingly and with intent to defraud any insurance company or other person files a 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.**

_____
Initials

_____ _____ _____
Print Name **Signature** **Date**

[1]If you are requesting reimbursement for a COVID-19 diagnostic test received at a Provider setting (e.g. laboratory), please use the standard reimbursement form.