COVID-19 TESTING
MEMBER REIMBURSEMENT FORM

Preferred United Plans®
"Alternative Funding"

Please complete the attached form and submit the required documentation for reimbursement for COVID-19 tests that you have paid for out of your own pocket. To be eligible for reimbursement the following must apply:

- The test you received must be approved by the Food and Drug Administration. Check the FDA approved test list.
- You must provide documentation of the amount you paid.
- This form must be completed in full, signed and dated.

Reimbursement will not be approved without all of the documentation listed above. All fields below must be completed in order to process the request.

MEMBER INFORMATION		
Employer Name:		Group Number:
Last Name:	First Name:	Member ID:
Street Address:		
City:	State:	Zip:

PATIENT INFORMATION:		
Last Name:	First Name:	Date of Birth:

If you are requesting reimbursement for an at home test, please provide the following information:	
Manufacturer of the test (FDA approved list):	
Where was the test purchased? (i.e. Amazon, Walgreens, etc.)	
Date of purchase:	
Cost of test:	

Patient Attestation

Please check yes or no for all of the following questions related to the OTC test kit(s) you are submitting for reimbursement.

☐ Yes	☐ No	The test was purchased by the patient for personal use or the use of a covered plan member.
☐ Yes	☐ No	The test was purchased for employment purposes.
☐ Yes	☐ No	The test has been or will be reimbursed by another source.
☐ Yes	☐ No	The test has been or will be placed for re-sale.

I certify that the information on this claim form is correct and authorize release of all information to SecureOne and the Plan Sponsor. I also certify that the patient for whom this claim is made is eligible for benefits and does not have primary prescription drug coverage or medical coverage under any other group medical plan.

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If you are requesting reimbursement for a test provided by a health care provider, please provide the following information:			
Provider Type (Check One):	☐ Provider's Office ☐ Urgent Care Facility	☐ Laboratory/Mobile Lab ☐ Pharmacy	
☐ Other:_____			
Provider's Name:			
Provider's Address:			
Provider's National Provider Identifier (NPI):			
Date of Service (MM/DD/YYYY		Cost of Test:	$

I certify that the information listed on this form is true, the enclosed material is correct and unaltered, and the expenses were incurred by the patient listed above. False receipts or altering of this information will result in civil or criminal prosecution. I authorize the release of any information as described below.

Signature:	Date:	Phone Number:

We value your privacy. We won't release any information about you unless you ask us to in writing or we must do so to process or review your claim (by sharing with another insurance company, for example). We'll tell you which information we released, and to whom, if you request it.

Please make sure you provide the following documents with this form:

- For at home tests:
  - Receipt indicating the amount you paid.
- For test provided by a health care provider, the original bill or claim for the services that includes:
  - The laboratory or provider's name and address
  - The date of service
  - The appropriate procedure and diagnosis codes
  - The receipt indicating the amount you paid
- Keep copies of your original receipts for your files. We can't return originals to you.

Submit This Form and Documentation to:		
Mail: SecureOne Benefit Administrators, Inc. Attn: Claims Dept. P.O. Box N Grand Rapids, MI 49501-4914	**Fax:** 616-454-4338 Attn: Claims Dept.	**E-Mail:** claims@secureoneinc.com