



Sharp Direct Advantage® member reimbursement request form

# At-home COVID-19 tests

## Purpose

The purpose of this form is to ask for a refund from Sharp Health Plan for the cost of FDA approved at-home COVID-19 tests.

## Instructions

1. Reimbursement for approved charges will be mailed within 30 days of receipt of complete documentation.
2. Complete a separate form for each member who is requesting reimbursement. Only one form is needed per member.
3. The member who received the medical services must sign this form. If the member cannot write their name, then they may have a caregiver sign for them.
4. You will need the following information to complete this form.
  - The brand name of the at-home COVID-19 test that you purchased.
  - The Universal Product Code (UPC) from the box. The UPC code will be underneath the bar code and is typically a 12-digit number.
5. Send this completed form and the following documents to Sharp Health Plan. Incomplete forms and missing information may result in a delay or non-payment of your request. Please keep copies of all items sent to Sharp Health Plan, including the following:
  - Proof of payment in the form of an itemized receipt.
  - If you are requesting a reimbursement for more than 8 at-home tests per member per month, you will need to submit a physician's order stating that they were medically necessary.

## Submit

Please submit the finished form and required documents by mail or fax:



**By Mail:**

Attention: Claims Research  
Sharp Health Plan  
8520 Tech Way, Suite 200  
San Diego, CA 92123



**By Fax:**

Attention: Claims Research  
1-858-636-2276

**Member Information (Complete this section for all reimbursement requests.)**

First name:	Last name:	Middle initial:
ID#:	Phone number: (     )	Birth date (MM/DD/YY): /      /
Home address:		
City:	State:	ZIP code:

Please include the brand name of the at-home COVID-19 test that you purchased, and the Universal Product Code (UPC) from the box. The UPC will be underneath the barcode and is typically a 12-digit number.

Was test purchased as a result of an exposure at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, give the date of the incident:
--	--

**Other Health Coverage (Complete this section if you have other health coverage.)**

Other health plan name:	Health plan phone number: (     )	Effective date of other coverage (MM/DD/YY):
Policy holder's name:	Policy holder's ID#:	Policy holder's birth date (MM/DD/YY):
Type of coverage: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Other	Type of policy: <input type="checkbox"/> Self only <input type="checkbox"/> Self and spouse <input type="checkbox"/> Family <input type="checkbox"/> Other	

## Certification Statement

I attest that the COVID-19 tests for which I am requesting reimbursement were purchased for my personal use, were not purchased for employment purposes, have not been (and will not be) reimbursed by another source, and have not been (and will not be) given or sold to another individual or entity.

I certify that the above information is true and the attached material is correct and unaltered and that the expenses were incurred by the patient named above. I understand all documents submitted become the property of Sharp Health Plan and will not be returned. I understand that if I submit false receipts or fraudulently altered documents, I may be disenrolled from Sharp Health Plan and/or subject to civil or criminal penalties. I authorize the release of any information needed to review or process this request.

Member's name:

Member's signature:

Date (MM/DD/YY):



**If you need assistance, we're here to help.** You can call Customer Care at 1-855-562-8853 or email us at [customer.service@sharp.com](mailto:customer.service@sharp.com). We are available to assist you 8 am to 8 pm, 7 days a week from October to March, and Monday through Friday from April to September.

**IMPORTANT:** Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call Sharp Health Plan right away at 1-858-499-8300 or 1-800-359-2002.

**IMPORTANTE:** ¿Puede leer esta carta? Si no le es posible, podemos ofrecerle ayuda para que alguien se la lea. Además, usted también puede obtener esta carta en su idioma. Para ayuda gratuita, por favor llame a Sharp Health Plan inmediatamente al 1-858-499-8300 o 1-800-359-2002.