How to submit your claim for an OTC COVID-19 Test

What Tests are covered? Your employer will cover any OTC COVID-19 test that meets federal requirements, which is self-administered, and the results are read by the member. Tests may be purchased at a retail store or online. Tests purchased at a retail location or online which are then sent to a lab for processing are not covered unless accompanied by a doctor's order (except for residents of plans based in the District of Columbia).

How do I get reimbursed for my OTC COVID-19 test?

Through mail

All required documentation listed below must be submitted to be reimbursed:

- Claim Form
- Purchase receipt clearly showing the date of purchase and testing kit charges;
- The attestation form attached to these instructions; and
- UPC code from **each** OTC COVID-19 test package being submitted (UPC codes should be taped to a sheet of paper, photographed or scanned)

Mail to the address listed on the top of the claim form.

Online

Complete the online claim available in the member portal per the instructions below:

1. Go to ncas.com > members
2. Select "Login or Register"
3. On the member portal home page, select "Submit an Out of Network Claim"
4. Select the "Choose File" button and upload your attachments:
    - A completed claim form (attached to these instructions);
    - A completed attestation form (attached to these instructions);
    - A photo or scan of your
        - Original receipt; and
        - The UPC code cut out from the box of each COVID test being submitted.

Example of UPC code:

Completing the claim form:

The following sections of the claim form must be completed

1. Name of Employee / Employee's Date of Birth / Employee's ID Number
2. Employee's Address
3. Employee's Sex / Employee's Marital Status / Employer Name
4. Other Insurance Information (if applicable)
5. Patient's Name / Patient's Date of Birth
6. Patient's Relationship to Employee
7. Patient's Sex / Dependent Child Information

(Cont.)

8. Diagnosis, nature of illness or injury – **Enter COVID At-Home Test**
9. Indicate whether the test is related to employment
10. List Below Only Those Charges Being Claimed
    - Name of Provider – **Enter location purchased and name of test**
    - Description of Services – **Enter A9150 and number of tests in the unit (box) purchased. If a box contains 2 test you would enter – 2 tests, if a box contained a single test you would enter 1 test**
    - Diagnosis **– Enter Z11.52**
    - From Date **– Enter date purchased (from receipt)**
    - Charge **– Enter the cost of the COVID test(s) purchased** (you may include tax and standard shipping costs.) Express, Rush or Overnight Shipping charges will not be reimbursed)
11. Total – **Enter the total charges on the claim**
12. **Sign the claim form either electronically or physically**

Example:

16. LIST BELOW ONLY THOSE CHARGES BEING CLAIMED AND ATTACH ORIGINAL ITEMIZED BILLS FROM THE PROVIDER FOR THESE SERVICES

	NAME(S) OF PROVIDER(S)	DESCRIPTION(S) OF SERVICE(S)	DIAGNOSIS (IF MORE THAN ONE)	FROM DATE (MO / DAY / YEAR)	TO DATE (MO / DAY / YEAR)	CHARGE
A.	Walmart / BinaxNOW	A9150 - 2 tests	Z11.52	01 / 15 / 22	/ /	$ 24 . 99
B.	RiteAid/iHealth	A9150 - 2 tests	Z11.52	01 / 15 / 22	/ /	$ 20 . 50
C.				/ /	/ /	$.
D.				/ /	/ /	$.

17. TOTAL $ 45 . 49

Claim form is located on the next page.

MEDICAL CLAIM FORM

INSTRUCTIONS:

1. **Complete Employee's Statement and Attestation Statement below**
2. **Attach ALL required documentation**
3. **Submit online by logging to your account on NCAS.com or send claim form, attestation and required documentation to:**
   Mail Administrators
   PO Box 981608
   El Paso, TX 79998

EMPLOYEE'S STATEMENT

NAME OF EMPLOYEE (*First name, middle initial, last name*) | EMPLOYEE'S BIRTHDATE | EMPLOYEE'S ID NUMBER (from medical card)

EMPLOYEE'S ADDRESS (NO.) (STREET) (CITY) (STATE) (ZIP)

EMPLOYEE'S SEX
MALE ☐ FEMALE ☐

EMPLOYEE'S MARITAL STATUS
☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ LEGALLY SEPARATED

EMPLOYER NAME

IS COVERAGE FOR THIS CLAIM PROVIDED BY ANY OTHER GROUP INSURANCE, FEDERAL PROGRAM (INCLUDING MEDICARE), EMPLOYER, UNION, STUDENT OR ASSOCIATION PLAN? ☐ YES ☐ NO
IF YES, PROVIDE NAME AND ADDRESS OF INSURANCE COMPANY | POLICY NUMBER

NAME OF PATIENT | PATIENT'S BIRTHDATE | PATIENT'S RELATIONSHIP TO EMPLOYEE ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

PATIENT'S SEX
MALE ☐ FEMALE ☐

IF CLAIM FOR A DEPENDENT CHILD, DO YOU HAVE LEGAL CUSTODY? ☐ YES ☐ NO
IS CHILD MARRIED? ☐ YES ☐ NO

DIAGNOSIS, NATURE OF ILLNESS OR INJURY

IS CONDITION RELATED TO EMPLOYMENT? ☐ YES ☐ NO

LIST BELOW ONLY THOSE CHARGES BEING CLAIMED AND ATTACH ORIGINAL ITEMIZED BILLS FROM THE PROVIDER FOR THESE SERVICES

NAME(S) OF PROVIDER(S)	DESCRIPTION(S) OF SERVICE(S)	DIAGNOSIS (IF MORE THAN ONE)	FROM DATE (MO / DAY / YEAR)	TO DATE (MO / DAY / YEAR)	CHARGE
A.			/ /	/ /	$.
B.			/ /	/ /	$.
C.			/ /	/ /	$.
D.			/ /	/ /	$.
				TOTAL	$.

AUTHORIZATION: The above answers are true and correct to the best of my knowledge. I hereby authorize any physician, practitioner or other person, any hospital, including veteran's administration or government hospital, any medical service organization, any insurance company, or other institution, or organization, to release to each other any medical or other information acquired, including benefits paid or payable, concerning this or other liabilities. A photostat of this authorization shall be as valid as the original.

DATE | EMPLOYEE'S SIGNATURE | PATIENT'S SIGNATURE (PARENT OR GUARDIAN IF PATIENT IS A MINOR)

NCAS provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Attestation Statements for OTC At-Home Rapid Antigen COVID Tests

Member ID:______________________ Patient Name: ________________________________

Under a requirement of the federal government, your Employer will now reimburse members for over-the-counter (OTC), at-home COVID-19 tests. **The federal mandate only applies to tests purchased to identify potential COVID-19 infection.** OTC COVID-19 tests used for surveillance testing and employment purposes are not covered.

Please initial each item below and attach this document to your claim form.

_____ I agree that the expenses for the OTC at-home COVID-19 test(s) are correct and were incurred by the above-named member.

_____ I agree that the OTC at-home COVID-19 test(s) was purchased on or after January 15, 2022.

_____ I agree that the purchase of the OTC at-home COVID-19 test(s) listed above are not for surveillance, or for the purposes of my employment. (e.g., satisfying an employer's requirement to test weekly).

_____ I agree that the expenses listed on the claim form for the OTC at-home COVID-19 test(s) have not been, nor will they be, reimbursed from another source, including employer, school, HSA/FSA or other insurer.

_____ I agree that I will not resell, give or supply the OTC at-home COVID-19 Test(s) to any other persons or entities other than my family members covered by my employer's health plan.