Northern Light. Beacon Health

Employee Health Plan

Beacon Health
PO Box 21116
Eagan, MN 55121

Instructions for requesting reimbursement for COVID home test kits

Use the Claim Reimbursement Form only for COVID Home test kits purchased for you or a covered member on the policy.

To be eligible for reimbursement, the following must apply

- The purchase date was 1/15/22 or later
- The test was purchased for your personal use, or the personal use of a family member covered under your health plan (e.g., not for resale)
- A separate claim reimbursement form is required if reimbursement is needed on more than one covered family member.
- The test you purchased must have been approved or granted Emergency Use Authorization (EUA) by the Food & Drug Administration (FDA) and labeled for home use. Check the EUA list for approved at home covid tests.
- You must provide documentation that includes the amount you paid, the specific test purchased, and the total number of tests (individual tests, not per package) purchased.
- You must provide a copy or photo of the barcode from the test package, if available.
- No more than 8 individual tests are included in a single claim per calendar month. Individual tests are the number included in each package and not per package.
- By submitting a claim form for COVID home tests, you are agreeing that the above conditions are met.

Next steps

To help process your claim, the form must be fully completed, signed, and returned with all required documents.

Send your documents one of two ways:

.

Mail to:
Beacon Health
PO Box 21116
Eagan, MN 55121

Questions?

Call:
855-429-1023
Monday through Friday

8 a.m. to 6 p.m. Eastern Time

Beacon Health
PO Box 21116
Eagan, MN 55121

Over-The-Counter Home COVID-19 Test Reimbursement Request

General Information (See ID card)

Patient's name (first, MI, last)

Subscriber name (Who the insurance is listed under)

ID number

Group number

Relationship to patient

Patient's phone number

Patient's birthday (mm/dd/yyyy)

☐ I consent to receive voicemails at this number containing my personal healthinformation related to this claim.

Section A — Other Health Plan Information

Does the patient have any other health insurance coverage?

☐ Yes*

☐ No
Then, skip to section B

*If the patient's other insurance pays for care first, you must submit the claim to them before we can process your request.

Name of other health plan

Phone number

ID number

Please attach the Explanation of Benefits (EOB) from the other health plan.

Section B — Claim Details

Has the patient paid the total amount due for this claim?

☐ Yes
Then, attach an itemized bill,

☐ No

Required information:

Manufacturer Name

Where was the test purchased?

Date of purchase (month/day/year)

Total Cost of the Test(s)

Quantity (multiple tests can be included per package, please list total number of tests)

Reason for the test

☐ I was exposed to someone with COVID-19 *(Z20822)*

☐ I had COVID-19 symptoms *(Z0389)*

☐ Other _____

Use Only |TIN- 999999999 | Procedure- 87426 | POS- 12

Section C — Signature

To help process your claim, this form must be fully completed, signed and returned. Please refer to the checklist on the instructions page to ensure you've met all requirements.

By signing below, I certify that this OTC COVID-19 at home test was purchased by the participant, beneficiary, or enrollee for personal use by the person listed as patient on this form who had signs or symptoms consistent with COVID-19, or was asymptomatic, but had recent known or suspected exposure to SARS-CoV-2.

Patient signature (or legal guardian)	Printed name (first, MI, last)	Date (mm/dd/yyyy)
x		

Please note: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.