SecurityHealth Plan℠
Promises kept, plain and simple.®

1515 North Saint Joseph Avenue
PO Box 8000
Marshfield, WI 54449-8000

1.800.472.2363 | 715.221.9555
TTY 711
Fax: 715.221.9500

Member COVID-19 Over-the-counter Testing Reimbursement Request

To seek reimbursement from Security Health Plan for over-the-counter COVID-19 tests, complete this form, including your signature and the date you complete the form. Keep a copy of all documents you submit, including this form, and allow 30 days for processing. After your claim is processed, we will send you a Personal Health Statement *(Explanation of Benefits or EOB)* and if your reimbursement request is approved, a check made out to the subscriber of your policy.

If submitting reimbursement for more than one plan member, complete a separate form for each person.

Limit form submissions to one per month per plan member. Reimbursement is limited to 8 individual COVID-19 antigen rapid at-home tests (a 2-pack is equal to 2 individual tests) per plan member, per month, unless ordered or administered by a health care provider following an individualized clinical assessment.

In order to receive reimbursement the following must apply:

- Valid proof of payment and original UPC label (for each test kit) must be provided with the completed form below.
  - This must include proof of the date purchased and amount paid.
- If you are asking for reimbursement of more than 8 tests for a plan member in a month, a copy of the health care provider's order is required.
- The test was not performed for employment or travel screening purposes.

Member Requesting Reimbursement (person taking the test)		
Last name		
First name		
Date of birth (mm/dd/yyyy)	Member ID	Phone

Other Information

Manufacturer of the test (must be FDA approved): _____

Where the test was purchased: _____

Date of purchase (MM/DD/YYYY): _____ /_____ /_____

Cost of the test: $ _____

Reason for the test:

- ☐ Member was exposed to someone with COVID-19.
- ☐ Member had COVID-19 symptoms.
- ☐ Other (explain): _____

Manufacturer of the test (must be FDA approved): _____

Where the test was purchased: _____

Date of purchase (MM/DD/YYYY): _____ /_____ /_____

Cost of the test: $ _____

Reason for the test:

- ☐ Member was exposed to someone with COVID-19.
- ☐ Member had COVID-19 symptoms.
- ☐ Other (explain): _____

Manufacturer of the test (must be FDA approved): _____

Where the test was purchased: _____

Date of purchase (MM/DD/YYYY): _____ /_____ /_____

Cost of the test: $ _____

Reason for the test:

- ☐ Member was exposed to someone with COVID-19.
- ☐ Member had COVID-19 symptoms.
- ☐ Other (explain): _____

Manufacturer of the test (must be FDA approved): _____

Where the test was purchased: _____

Date of purchase (MM/DD/YYYY): _____ /_____ /_____

Cost of the test: $ _____

Reason for the test:

- ☐ Member was exposed to someone with COVID-19.
- ☐ Member had COVID-19 symptoms.
- ☐ Other (explain): _____

I certify the above information is true, the enclosed material is correct and unaltered, and the expenses were incurred for the member listed above.

_____ _____ /_____ /_____

Signature Date (MM/DD/YYYY)

Once form is completed, mail this document within 15 months of date the test was purchased, along with proof of payment and the original UPC code for each test kit to:

Security Health Plan
Attn: Claims
PO Box 8000
Marshfield, WI 54449

Notice of Nondiscrimination

Security Health Plan of Wisconsin, Inc., complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, religion, disability, age, sex, gender identity, sexual orientation, health status, marital status, arrest or conviction record or military participation.

Limited English Proficiency Language Services

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-800-472-2363 (TTY 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-472-2363 (TTY 711).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-472-2363 (TTY 711).

If you require materials in large print, please call 1-800-472-2363 (TTY 711).

