Sanford Health Plan
PO Box 91110
Sioux Falls, SD 57109

SANFORD HEALTH PLAN

COVID Test Kit Claim Form

Subscriber ID (from subscriber ID card):

Member Information

Name (Last, First, MI):

Mailing Address:

City: State: Zip Code:

Phone #: ( ) -

Date of Birth (Member) / /

Gender: ☐ M ☐ F

New Address? ☐ Yes ☐ No

Relationship to Subscriber:

☐ Subscriber ☐ Child
☐ Spouse/Partner ☐ Other Dependent

Subscriber Information

Name (Last, First, MI):

Phone #: ( ) -

Mailing Address:

City: State: Zip Code:

Date of Birth (Subscriber) / /

New Address? ☐ Yes ☐ No

EXPENSES

- One (1) Claim form per member
- Only FDA-approved COVID-19 at-home test kits are eligible for reimbursement. Please check the appropriate box(es) corresponding with your claim(s):

COVID Test Kit Product Label Name

☐ BD VERITOR AT-HOME COVID-19 TEST	☐ IHEALTH COVID-19 ANTIGEN RAPID TEST
☐ BINAXNOW COV KIT HOME TEST	☐ INTELISWAB KIT COVID-19
☐ CARESTART COVID-19 ANTIGEN HOME TEST	☐ MAXIMBIO CLEARDETECT COVID-19 ANTIGEN HOME TEST
☐ CELLTRION DIATRUST COVID-19 AG HOME TEST	☐ ON/GO COVID KIT ANTIGEN
☐ CLINITEST RAPID COVID-19 ANTIGEN SELF-TEST	☐ QUICKVUE HOME KIT COVID-19
☐ ELLUME COV19 KIT HOME TEST	☐ SCOV-2 AG DETECT RAPID SELF-TEST
☐ FLOWFLEX KIT HOME TEST	☐ SD BIOSENSOR, INC. COVID-19 AT-HOME TEST
☐ FLOWFLEX KIT TEST	

- Complete documentation for the above in the next section.

DOCUMENTATION

- To be reimbursed for over-the-counter expenses, member must enclose a detailed receipt showing the over-the-counter item purchased on or after January 15, 2022. This itemized receipt must include the date of purchase, the merchant's name, and the description of the items purchased. Please complete the table below and attach your receipt to this claim form.

Purchase Date	Merchant	Quantity	Product Name *UPC Code Optional*	Purchase Price	Shipping	Tax	Item Total
						Grand Total:	

Mail claim form by U.S. Postal Services (USPS) to:

Sanford Health Plan
PO Box 91110
Sioux Falls, SD 57109-1110

- To be eligible, member must be an active member of Sanford Health Plan on date of purchase.
- One member per form is allowed for up to eight tests per calendar month.
- Recommended to submit one claim per month per member with appropriate documentation.
- Only claims submitted through USPS will be processed.
- All paper claims must include an itemized receipt.
- Signed attestation is required: If no receipt is included, or form is unsigned, form will be returned to member for additional information.
- All reimbursement will be made to Subscriber (for Spouse and all dependents).
- A maximum of eight tests per month per member per receipt. *For example:* If a member purchases sixteen tests in one month, they are eligible for reimbursement for only eight of the sixteen tests purchased in that month. The remaining eight test are not eligible for reimbursement.
- Address information provided on form will be validated against current information in the Sanford Health Plan System.

Attestation and Signature (Unsigned claim forms will not be considered for reimbursement)

I, the undersigned, certify that the above expenses were incurred by me (and/or my Spouse/eligible dependents) on or after January 15, 2022. I also certify that the above expenses paid by me (or them), were not reimbursed by any other coverage option from a private or public entity. I have attached an itemized receipt, and understand I can only be reimbursed for FDA approved tests up to a limit of eight tests per covered member per calendar month. I am stating that the information above is correct and reimbursement is only for the member named above. I understand the tests are for individual diagnostic testing and do not qualify for employer or other non-diagnostic related use that is not reimbursable. I understand these tests are for personal use and are not eligible for re-sale or distribution. I understand engaging in re-sale or distribution activities constitutes an act of fraud against the health plan and could result in the loss of health benefits and bring civil or criminal liability.

Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

_____ _____

Subscriber Signature Date