How to complete and submit the Express Scripts form

for reimbursement of covered at-home COVID-19 tests.

The Express Scripts form must be completed and sent, along with your receipt/s (original or copies) to:

Express Scripts

ATTN: Commercial Claims
P.O. Box 14711
Lexington, KY 40512

You can also fax your materials to 608-741-5475. If you have questions, please call the number on the back of your member ID card. A Customer Care member will be happy to help.

Click here to download the Express Scripts reimbursement form

Please follow these steps to complete the Express Scripts reimbursement form for your COVID-19 at home tests:

This section asks for your basic member information. Not all members will have a Group No. Leave this blank if you don't see one on your member ID card. Be sure to complete a separate form for each member.

» Cardholder Information *See your prescription drug ID card.*

Group No. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Member ID ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Member Name First ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Last ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Street Address ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

City ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ State ☐☐ ZIP ☐☐☐☐☐

» Patient Information

Patient Name First ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Last ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Patient Date of Birth (Month/Day/Year) ☐☐/☐☐/☐☐☐☐

Sex

- ☐ Female
- ☐ Male

Relationship to Plan Member

- ☐ 1 Self
- ☐ 2 Spouse
- ☐ 3 Eligible Child
- ☐ 4 Dependent Student
- ☐ 5 Disabled Dependent
- ☐ 6 Dependent Parent
- ☐ 7 Non-spouse Partner
- ☐ 8 Other

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This section is for information about where you purchased your test/s. Complete only the portion highlighted by the red box. You do NOT need to complete the area in gray. If test/s were purchased at a non-pharmacy retailer, be sure to use the name and information of where purchased. If test/s were purchased online, include only the name of the online retailer.

›› Pharmacy Information

Name of Pharmacy

Street Address

City State ZIP

Telephone (include area code) ☐☐☐-☐☐☐-☐☐☐☐

Is this an on-site nursing home pharmacy? ☐ **Yes** ☐ **No**

I hereby certify that the charge(s) shown for the medication(s) prescribed is correct and agree to provide Express Scripts or its agents reasonable access to records related to medication dispensed to this patient in accordance with applicable law. I further recognize that reimbursement will be paid directly to the plan member and assignment of these benefits to a pharmacy or any other party is void.

X _____ NCPDP/NPI Required

Signature of Pharmacist or Representative **(Required)** ☐☐☐☐☐☐☐☐☐☐

Check the "Covid Test Kit" box and fill in the information.

›› Claim Receipts

Tape receipts or itemized bills on the back.

Check the appropriate box:

☐ **Compound Prescription**
Make sure your pharmacist lists ALL the VALID NDC numbers, cost and quantities for each ingredient on the back of this form and attach receipts.

☐ **Medication Purchased Outside of the United States**
Country _____

Currency used _____

☐ **Allergy Medication**

☐ **Covid Test Kit**
Kit Name _____

Number of Kits _____

Purchase Date _____

You do NOT need to complete the Coordination of Benefits section of the form.

Coordination of Benefits

(Another Health Plan has paid a portion.) Mark the appropriate box for your primary coverage method. See the back for more information.

Is this a coordination of benefits claim?

☐ Yes ☐ No

☐ Another Health Plan paid and you are enclosing a statement that outlines how much you paid and how much the other carrier paid (1)

☐ Card Program (3)

☐ Express Scripts Mail Order (4)

Be sure to sign and date the form. Tests purchased only for yourself or your covered dependents may be eligible for reimbursement under your coverage benefits. These tests are not for resale purposes.

›› Acknowledgment

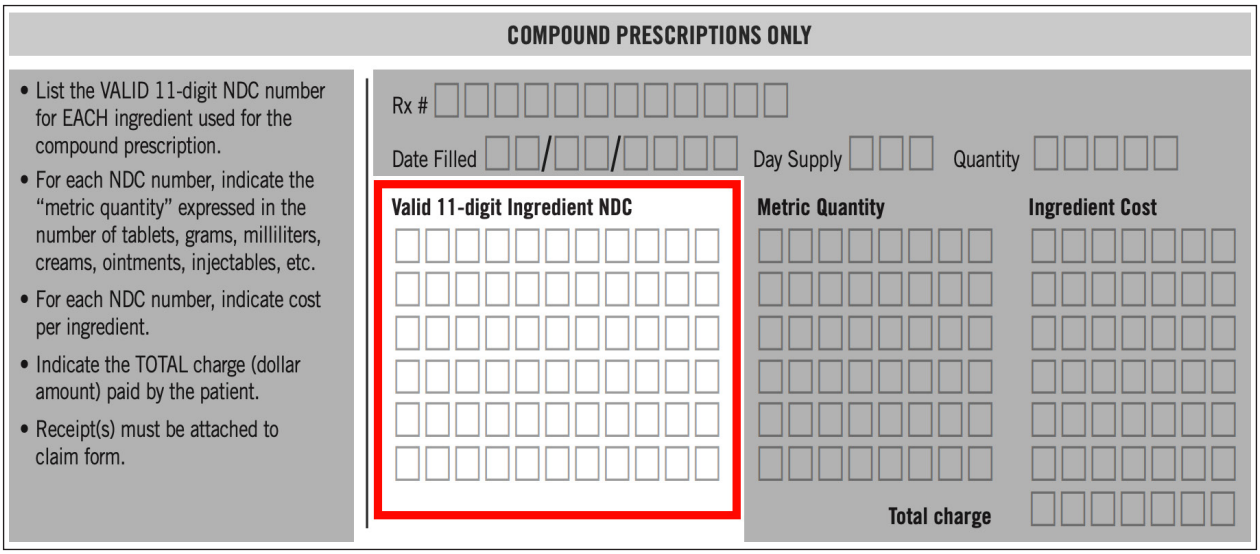
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals information concerning any fact material thereto for the purpose of misleading, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of each violation. If this is a claim for a COVID test kit, the test was purchased for personal use or the use of a covered plan member and was not purchased for employment purposes. This test will not be reimbursed by another source nor placed for resale.

X _____ _____

Signature of Member Date

*If allowed by law, you may assign the payment of this claim to your pharmacy. If your pharmacy is willing to accept assignment, do not complete this form. Please request that your pharmacy contact Pharmacy Services at 800.922.1557 for assistance.

This section is for information about the at-home COVID-19 test(s) you purchased. **Complete only the area highlighted by the red box.** National Drug Codes (NDC) tell us what product you purchased. Not all tests currently have NDC codes.



Please cut the NDC/UPC code from the box and include it with the completed claim form and receipt/s. Only one is needed if all boxes have the same code. If the boxes have different codes, please submit one NDC/UPC for each unique code. If you purchased more than one of the same brand of test, only list it once in this area. Your receipt/s will note the date/s and quantity/quantities purchased.

Below is a list of FDA-approved COVID-19 at-home tests with NDC codes that are currently available.

Note: If your FDA-approved test is not on the list, write the full brand name of the test on the form and the NDC or UPC code printed on the box.

PRODUCT NAME	PACKAGE QUANTITY	NDC OR UPC
BinaxNow Covid 19 Antigen Self Test	2	11877001140
CareStart Covid 19 Antigen Home Test	2	50010022431
Clinitest Covid 19 Home Test	5	16490002574
COVID-19 At-Home Test	1	00111070752
COVID-19 At-Home Test	4	00111070772
Ellume COVID-19 Home Test	1	56964000000
FLOWFLEX COVID-19 AG HOME TEST	1	82607066026
FLOWFLEX COVID-19 AG HOME TEST	2	82607066027
FLOWFLEX COVID-19 AG HOME TEST	5	82607066028
I Health Covid 19 Antigen Home Test	2	56362000589
I Health Covid 19 Antigen Home Test	5	56362000590
INTELISWAB COVID-19 HOME TEST	2	16490002574
On-Go COVID-19 Antigen At-Home Test	2	60006019166
QuickVue At-Home COVID-19 Test	5	14613033968
QuickVue At-Home COVID-19 Test	2	14613033972

Coverage of Rapid, At-Home COVID-19 Tests: Terms and Conditions

Excellus BlueCross BlueShield covers at-home COVID-19 tests at no cost for many members with our pharmacy benefits.

To see who is eligible for reimbursement of at-home COVID-19 tests, please visit our website at

ChooseExcellus.com/COVID19

For additional information and details on your plan and benefits related to COVID-19, check our **Member Coverage and Support** page.

Please note the following regarding coverage for COVID at-home tests at no cost:

- Tests must be authorized by the U.S. Food and Drug Administration (FDA) and not require a lab for processing.
- No-cost coverage is for at-home tests purchased for any reason except to fulfill an employment, school or travel requirement (per the federal guidelines).

There is no coverage if the test has been (or will be) reimbursed from any other source.

The number of covered tests, amount of your health plan's reimbursement, and the date when this coverage is no longer available are set by applicable law.

When you submit a request for reimbursement:

- The receipt from the seller must show the (1) date of purchase and the (2) price of the test(s).
- Cut out the NDC/UPC code from the box and include it with the completed claim form and receipt/s. Only one is needed if all boxes have the same code.
- If submitting for an FDA-approved test that is not on the published list, include the full brand name of the test on the claim form and the NDC or UPC code printed on the box.

Plan terms and conditions apply. See your plan documents for claim filing deadlines, appeals and grievance rights, etc.

Note: If your health care provider orders the test, these rules do not apply.

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