COVID-19 Over-the-Counter (OTC) Test Kit Claim Form

Use for COVID-19 over-the-counter (OTC) testing kits only. Please complete one form per customer. For all other claims, please use the Medical Claim Form: https:/www.cigna.com/memberrightsandresponsibilities/member-forms/

Section 1: Describe the Test Kit(s)

Please answer the following questions about the test(s) for which you are seeking reimbursement under your Cigna medical plan.

Please select the response that best describes the type of test for which you are seeking reimbursement.

☐ An at-home, over-the-counter (OTC) rapid result test, visually read and results interpreted by the customer.

☐ An at-home, specimen collection kit where the specimen is sent to a lab or other facility for processing and interpretation of results. (**STOP:** This form should not be used to request reimbursement for specimen collection kits processed by a lab or other facility. Use the standard medical claim form instead.)

Please select the product/brand. (select all that apply)

Please select the OTC at-home test kit you purchased:

☐ BinaxNOW COVID-19 Ag Card Home Test (Abbott)	☐ SCoV-2 Ag Detect Rapid Self-Test (InBios)
☐ BinaxNOW COVID-19 Ag Card 2 Home Test (Abbott)	☐ InteliSwab COVID-19 Rapid Test (OraSure)
☐ BinaxNOW COVID-19 Antigen Self-Test (Abbott)	☐ Celltrion DiaTrust COVID-19 Ag Home-Test (Celltrion)
☐ COVID-19 At-Home Test (SD Biosensor)	☐ QuickVue At-Home OTC COVID-19 Test (Quidel)
☐ CLINITEST Rapid COVID-19 Antigen Self-Test (Siemens)	☐ QuickVue At-Home COVID-19 Test (Quidel)
☐ iHealth COVID-19 Antigen Rapid Test (iHealth Labs)	☐ InteliSwab COVID-19 Rapid Test Rx (OraSure)
☐ CareStart COVID-19 Antigen Home Test (Access Bio)	☐ Flowflex COVID-19 Antigen Home Test (ACON)
☐ BD Veritor At-Home COVID-19 Test (Becton Dickinson)	☐ Ellume COVID-19 Home Test (Ellume)

Date of Purchase: MM / DD / YYYY | Number of Boxes: | Tests per Box: | Total Cost: $

Section 2: Customer Attestation

Please check yes or no for all of the following questions.

Yes	No	*The over-the-counter test kit submitted for reimbursement on this form:*
☐	☐	Was purchased by the customer for personal use or the use of a covered plan member
☐	☐	Was purchased for employment purposes
☐	☐	Has been (or will be) reimbursed by another source
☐	☐	Has been (or will be) placed for resale

Section 3: Required Documentation

When submitting your OTC test-kit claim, please include the required documentation with your form. Incomplete submissions may not be considered for reimbursement.

- Purchase Receipt clearly showing the date of purchase and testing kit charges.

PRIMARY CUSTOMER INFORMATION: *Primary Customer complete this section*

A1. PRIMARY CUSTOMER'S NAME *(Last Name)*	*(First Name)*	*(M.I.)*	A2. GENDER	B. DATE OF BIRTH
			☐ M ☐ F	MM / DD / YYYY

C1. PRIMARY CUSTOMER'S MAILING ADDRESS *(No., Street)*	*(City)*	*(State)*	*(ZIP Code)*	DAYTIME TELEPHONE #
				( )

IS THIS A CHANGE OF ADDRESS? (Note: address must also be changed with Employer, if applicable)	D. CIGNA ID NUMBER OR PRIMARY CUSTOMER SOCIAL SECURITY NUMBER *(on the front of your Cigna ID card)*	E. ACCOUNT NO. (on the front of your Cigna ID card)
☐ Yes ☐ No		

F. EMPLOYER'S NAME	G. Primary Customer Status	*** EFFECTIVE DATE
	☐ EMPLOYED ☐ RETIRED*** ☐ COBRA*** ☐ DISABLED***	MM / DD / YYYY

PATIENT INFORMATION: *Complete this section only if the patient is not the primary customer*

A. PATIENT'S NAME *(Last Name)*	*(First Name)*	*(M.I.)*	*B. RELATIONSHIP TO PRIMARY CUSTOMER*	*C. DATE OF BIRTH*	*D. GENDER*
			☐ Spouse ☐ Child ☐ Other	MM / DD / YYYY	☐ M ☐ F

E. PATIENT'S ADDRESS – IF DIFFERENT THAN PRIMARY CUSTOMER'S ADDRESS (No., Street)	*(City)*	*(State)*	*(ZIP Code)*

F. AT THE TIME MEDICAL SERVICE WAS PROVIDED WAS THE PATIENT: ☐ EMPLOYED FULL-TIME ☐ STUDENT FULL-TIME ☐ N/A

FAMILY/OTHER COVERAGE INFORMATION:

Complete only if claim is for a dependent and/or other coverage is in effect

A. SPOUSE EMPLOYED?	IF NO, HAS SPOUSE BEEN EMPLOYED DURING THE LAST 12 MONTHS?	B. NAME OF SPOUSE (Last Name)	(First Name)	(M.I.)	SPOUSE'S DATE OF BIRTH
☐ Yes ☐ No	☐ Yes ☐ No				MM / DD / YYYY

C. NAME OF SPOUSE'S EMPLOYER	ADDRESS OF SPOUSE'S EMPLOYER (No., Street)	(City)	(State)	(ZIP Code)	TELEPHONE #
					( )

D1. IS THE PATIENT COVERED UNDER ANOTHER HEALTH INSURANCE PLAN? ☐ Yes ☐ No

If yes, please provide: NAME OF HEALTH INSURANCE COMPANY	EFFECTIVE DATE OF COVERAGE MM / DD / YYYY	POLICY NUMBER	TYPE OF PLAN (HMO or PPO) IF KNOWN

D2. IS THE PATIENT COVERED UNDER MEDICARE? ☐ Yes ☐ No

If you answered Yes to D1 and/or D2 above, and the other insurance company is primary, the please send us this form and (a) a copy of the explanation of benefits (EOB) and (b) the itemized bill(s) for this claim.

CERTIFICATION

Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act which is a crime. For residents in the following states, please see the last page of this form: Alaska, Arizona, California, Colorado, District of Columbia, Florida, Kentucky, Maryland, Minnesota, New Jersey, New Mexico, New York, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas, Virginia.

I certify that the information supplied is true and correct.

PRIMARY CUSTOMER'S SIGNATURE **DATE:** MM / DD / YYYY

X

NOTE: Cigna may disclose the information on this form to other persons and entities, including your employer (if your coverage is through your employer). We may need to do this to process the claim or administer the health plan.

SUBMISSION INSTRUCTIONS

1. Claim forms may be mailed to the address on the back of your id card.
2. Claim forms may be faxed to: 859.410.2422

MAILING INSTRUCTIONS

- If you are sending one claim, please do not staple or paper clip the bills or receipts to the claim form.
- If you are sending more than one claim in the same envelope, then please use a paper clip to keep the claim form and the receipt together.
- Send your completed claim form and receipt to the Cigna address listed on your ID card. If you have additional questions, please contact Customer Service using the toll-free number on your ID card.

Caution: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

IMPORTANT CLAIM NOTICE

Alaska Residents: A person who knowingly and with intent to injure, defraud or deceive an insurance company or files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Arizona Residents: For your protection, Arizona law requires the following statement to appear on/with this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California Residents: For your protection, California law requires the following to appear on/with this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado Residents: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maryland Residents: Any person who knowingly OR willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly OR willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota Residents: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Jersey Residents: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

New York Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed $5000 and the stated value of the claim for each such violation.

Oregon Residents: Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or, (2) conceals for the purpose of misleading, information concerning any material fact, may have committed a fraudulent insurance act.

Pennsylvania Residents: Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Rhode Island Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Tennessee Residents: 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.

Texas Residents: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Virginia Residents: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.