bac

CLAIM FORM – OVER THE COUNTER COVID TESTS

ANSWER ALL QUESTIONS FULLY, ATTACH RECEIPTS, AND EMAIL TO **BACCLAIMS@BACTPA.COM**, FAX TO BAC AT **(614) 863-0184**, OR MAIL TO **PO BOX 107, REYNOLDSBURG, OH 43068-0107**

A. STATEMENT OF PARTICIPANT: PLEASE ANSWER ALL QUESTIONS FULLY

EMPLOYERS NAME:

EMPOLYEE NAME (LAST, FIRST, M.):

SOCIAL SECURITY NUMBER:

HOME ADDRESS: CITY: STATE: ZIP CODE:

PHONE NUMBER:

DATE OF BIRTH (MM/DD/YYYY):

EMAIL ADDRESS:

IS THIS A NEW ADDRESS?: ◯ **NO** ◯ **YES**

B. COVID TEST PURCHASES (SEE REVERSE): ATTACH RECEIPT OR INVOICE

1. CLAIMANT: | DATE OF PURCHASE: | AMOUNT:
   PLACE OF PURCHASE (PHARMACY, STORE NAME, OR WEB SITE): | WORK RELATED: ◯ **NO** ◯ **YES**
2. CLAIMANT: | DATE OF PURCHASE: | AMOUNT:
   PLACE OF PURCHASE (PHARMACY, STORE NAME, OR WEB SITE): | WORK RELATED: ◯ **NO** ◯ **YES**
3. CLAIMANT: | DATE OF PURCHASE: | AMOUNT:
   PLACE OF PURCHASE (PHARMACY, STORE NAME, OR WEB SITE): | WORK RELATED: ◯ **NO** ◯ **YES**
4. CLAIMANT: | DATE OF PURCHASE: | AMOUNT:
   PLACE OF PURCHASE (PHARMACY, STORE NAME, OR WEB SITE): | WORK RELATED: ◯ **NO** ◯ **YES**
5. CLAIMANT: | DATE OF PURCHASE: | AMOUNT:
   PLACE OF PURCHASE (PHARMACY, STORE NAME, OR WEB SITE): | WORK RELATED: ◯ **NO** ◯ **YES**
6. CLAIMANT: | DATE OF PURCHASE: | AMOUNT:
   PLACE OF PURCHASE (PHARMACY, STORE NAME, OR WEB SITE): | WORK RELATED: ◯ **NO** ◯ **YES**

D. AUTHORIZATION:

THE EXPENSES SUBMITTED FOR PAYMENT HAVE NOT BEEN REIMBURSED AND ARE NOT REIMBURSABLE UNDER ANY OTHER HEALTH PLAN COVERAGE OR BY ANY OTHER FORM OF REIMBURSEMENT

X _____ _____

EMPLOYEE'S SIGNATURE (NOT VALID UNLESS SIGNED IN INK): **DATE SIGNED** (MM/DD/YYYY):

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.

E. INSTRUCTIONS:

ELIGIBLE HEALTH CARE EXPENSES:

Recently the Federal Government updated the Families First Coronavirus Response Act to require that plans cover COVID at home tests. Under this rule an eligible employee may be reimbursed for the purchase of over-the-counter COVID home tests with no out of pocket cost. Reimbursement is limited to:

- Tests purchased on or after 01/15/2022
- 8 tests per covered plan member per month
- No cost sharing for tests purchased within the provider network
- A limit of $12.00 per test for tests purchased outside the preferred provider network
- Eligible tests are for the medically appropriate diagnosis of COVID. *Employment based testing is not an eligible expense.*

SUPPORTING DOCUMENTATION (FOR ELIGIBLE HEALTH CARE EXPENSES)

The following supporting documentation must be attached to your claim form:

- A copy of the receipt clearly indicating the purchase of COVID at home tests.
  A receipt with a UPC code and cost only is not acceptable.
- If the claim is for your covered dependents who are covered under another group plan you must first submit the claim to the primary insurance plan and provide a copy of the EOB showing any non-covered portion before BAC can consider the claim for payment

HOW TO FILE CLAIMS:

1) **Email an image of the receipts/invoice along with this claim form to BACclaims@bactpa.com or**
2) **Mail a copy of the receipts/invoice along with this claim form to BAC at P. O. Box 107 Reynoldsburg, Ohio 43068,**
3) **Fax to BAC at (614) 863-0184**
4) **Secure Email service is available at http://www.bactpa.com/secureemail_frmsrc.html**

Reimbursement will be provided to you via paper check which will be sent to the home address we have on record.

MAIL COMPLETED FORM TO:
BAC, PO BOX 107
REYNOLDSBURG, OH 43068

OR FAX COMPLETED FORM TO BAC AT:
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