5300 S. Broadband Lane
Sioux Falls, SD 57108-2221
605-334-4000
Fax: 605-334-8717
dakotacare.com

Over-the-Counter (OTC) At-home COVID-19 Test Reimbursement Form

You can use this form to ask us to pay you back for over-the-counter at home COVID-19 tests that have been authorized by the Federal Drug Administration (FDA).

- Complete one form for each member in which OTC COVID-19 tests have been purchased.
- Use the fillable format to complete to email or fax back. You can also print your responses in black or blue ink.
- Include proof of payment (such as paid receipt) that includes the name of the test and UPC code along with this completed form. If we don't receive the required information, your request will not be processed.
- Reimbursement will be lesser of the cost of the test or $12 per test per member.
- Reimbursement is limited to 8 FDA-approved at-home COVID-19 tests per member every 30 days.

Member Name: _____

Member ID Number: _____

Group Name: _____

Group Number: _____

Date of Birth: _____

Date of Service/Purchase: _____

Provider/Retailer: _____

Purchase Amount: $ _____

CPT/Diagnosis Code: K1034 / Z11.52

How many tests are you submitting for reimbursement? _____

Name of the FDA authorized test purchased (e.g., BinaxNOW, QuickVue, Intelliswab, etc.):

_____

Member Signature: _____ Date: _____

When I sign above, I am stating that the information above is correct. 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.

Please mail, email, or fax this claim form to:
5300 S. Broadband Lane Sioux Falls, SD 57108-2221
Phone: 605-334-4000 Fax: 605-334-8717 Toll-Free: 1-800-325-5598
Email: customer-service@dakotacare.com