ESC
Essential StaffCARE

COVID-19 OTC AT-HOME TEST CLAIM FORM
Send this claim form to:
Planned Administrators Inc.
Attn: Claims
P.O. Box 6702, Columbia, SC 29260-6702

COVID-19 OVER-THE-COUNTER (OTC) AT-HOME TEST CLAIM FORM

Please use this claim form for reimbursement for OTC COVID-19 at-home test kits.

NOTE: Over-the-counter Covid-19 Test for the purposes of employment are not reimbursable.

IMPORTANT CLAIM FILING INSTRUCTIONS:

- Please review carefully and fully complete the form. An incomplete form will delay the processing of the claim.
- To be eligible for reimbursement, the insured must have incurred the out-of-pocket expenses and not been reimbursed by any other source.
- Insured must complete sections 1, 2, and 3.
- **Enclose supporting documentation with your claim form (please maintain a copy for your records).**
  - Supporting documentation includes:
    - The original receipt (not a photocopy) of the purchase of the at-home test. The receipt should include the amount paid and date the test was purchased; and
    - The original UPC/Barcode of the at-home test.
- Submit this claim form and supporting documentation to:

  Planned Administrators Inc.
  Attn: Claims
  P.O. Box 6702
  Columbia, SC 29260-6702

Questions? Call our toll-free Customer Service Line, 1-888-798-0803, Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time.
A language line is available for translation for most languages.

SECTION 1 – INSURED INFORMATION

Provide details of the Employer and Insured

Employer Name _____

Group Policy Number _____

Insured Name *(First Name, Middle, Last Name)* _____

SSN or Tax ID # _____

Gender ☐ Male ☐ Female

Address *(Street, City, State & Zip)* _____

Date of Birth *(mm/dd/yyyy)* _____

E-mail Address _____

Phone Number _____

Cell/Mobile Number _____

Do you authorize the delivery of confidential medical or benefit information via personal cell phone? ☐ Yes ☐ No

Via e-mail? ☐ Yes ☐ No

If Yes to either personal cell phone or e-mail, please **initial here** to confirm your response: _____

Does the insured have major medical insurance or other primary health insurance? ☐ Yes ☐ No
If Yes, provide name of insurance carrier and policy number: _____

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SECTION 2 – CLAIMAINT INFORMATION (FOR WHOM THE TEST WAS PURCHASED)

Complete if this claim is for a dependent of the covered employee:

☐ Claimant is same as Insured (if you check this box, you may skip to **Section 3)**

Claimant Name *(First Name, Middle, Last Name)* _____

Date of Birth *(*mm/dd/yyyy*)* _____

SSN or Tax ID # _____

Relationship (To Insured) _____

E-mail Address _____

Phone Number _____

Cell/Mobile Number _____

Check all that apply – I authorize the delivery of confidential medical or benefit information via personal cell phone and/or email?
☐ Personal cell phone ☐ Email. ☐ None

If Yes to either personal cell phone or e-mail, please **initial here** to confirm your response: _____

Complete Mailing Address *(Street, City, State & Zip)*

_____

Is the child incapacitated/disabled? ☐ Yes ☐ No **Is the child married or in a partnership?** ☐ Yes ☐ No

SECTION 3 – COVID TEST MANUFACTURE INFORMATION

COVID-19 TEST MANUFACTURE INFORMATION

Manufacture of the test:_____

Where was the test purchased (for example – pharmacy)? _____

Purchase Date:_____ Number of test(s):_____ Cost of the test(s): $_____

As a reminder the following documentation is required for reimbursement:

- The original receipt (not a photocopy) of the at-home test must include the amount paid and purchase date; and
- The original UPC/Barcode of the at-home test.

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FRAUD NOTICES

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Alaska: ALASKA LAW REQUIRES US TO NOTIFY YOU OF THE FOLLOWING: Any person who knowingly and with intent to injure, defraud, or receive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For your protection **Arizona** law requires the following statement to appear on this form: Any person who knowingly presents a false or **fraudulent** claim for payment of a loss is subject to criminal and civil penalties. Penalties may include imprisonment, fines, denials of **insurance** and civil damages.

California: For your protection, California law requires the following to appear on 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: 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.

Delaware, Idaho, Indiana and Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

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

Kansas: Any person who knowingly and with intent to defraud any insurance company or other person by presenting any written statement as part of an application for insurance, the rating of an insurance policy, or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto has committed a fraudulent insurance act.

Kentucky: 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.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

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

New Mexico: 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: 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 five thousand dollars and the stated value of the claim for each such violation.

Oregon: Any person who, with an intent to knowingly defraud or knowingly facilitate a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement or a material fact, may be guilty of insurance fraud.

Pennsylvania: 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.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Tennessee, Virginia and Washington: 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.

All Other States Not Listed Separately: 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.

SECTION 4 – CLAIMANT AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

This authorization is designed to satisfy the requirements of the Health Insurance Portability and Accountability Act of 1996, as it may be amended from time to time (HIPAA).

By signing this authorization form, I agree to the following:

I authorize any physician, healthcare professional, hospital, clinic, Veterans Administration or other medical or medically-related facility, care provider or evaluator, insurance company, or insurance support organization that has such information, to disclose the following health information about me:

- Information as to the diagnosis, treatment or prognosis of my physical and mental health, including information related to office visits, prescriptions, outpatient treatments, medical test results and other similar information.
- Information about drug abuse, alcoholism, mental illness and communicable or infectious conditions such as Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency (AIDS) or sexually transmitted diseases. This authorization does not include psychotherapy notes. HIPAA's Privacy Rule requires a separate authorization for access to psychotherapy notes.

Such health information about me may be disclosed to BCS Insurance Company (BCS) and any representatives performing services for BCS, including its insurance support organizations, third-party administrators, affiliates, and any reinsurers. I understand that I have the right to request access to all personal information collected and, upon written request, I may ask BCS to correct, amend or delete any incorrect personal information.

I acknowledge that if a party or organization receiving my protected health information is not a health plan or health care provider, subject to federal health information privacy laws, then the information described above may be disclosed to others and no longer be protected by such laws. A copy of BCS' "Notice of Privacy Practices" is available upon request.

This authorization shall be valid for a period of 24 months from the date signed (in AZ, 180 days) (in VA, 30 months). A photocopy of this authorization shall be as valid as the original. I understand that I, or my authorized representative, may receive a copy of this authorization upon request. This authorization may be revoked at any time subject to the rights of anyone who acted in reliance upon the authorization prior to notice of its revocation. This authorization may be revoked upon submission of a written notice to BCS' Administrative Office.

I certify the information provided for reimbursement of this claim is true for the expenses incurred by the covered insured as listed above, the enclosed documentation is unaltered, and I was not reimbursed from any other source. I understand that providing false receipts or the altering of submitted documentation will result in civil or criminal prosecution. I also understand that although my signature on this form is voluntary, I understand it is required to determine my eligibility for benefits under an insurance policy issued by BCS Insurance Company (BCS). Without my signature, I understand my claim for insurance benefits may be denied. By signing, I also acknowledge that if a party or organization receiving my protected health information is not a health plan or health care provider, subject to federal health information privacy laws, then the information described above may be disclosed to others and no longer be protected by such laws. However, BCS does require its agents and service providers to protect the confidentiality of health information.

My signature below represents my acknowledgement, acceptance and authorization for all statements above.

Print Claimant Name _____ **Date** _____ **Phone Number** _____

Claimant Signature *(if claimant is over age 18)* _____ _____