OVER THE COUNTER (OTC) COVID-19 TEST REQUEST FOR REIMBURSEMENT FORM

Instructions: Please use this form to ask us to pay you back for any covered COVID-19 test(s) that you purchase either at the store, pharmacy or online. To see the full list of covered tests, visit **MIRx_covered_ndcs_covidtests.pdf**. You must have the name of the test on the receipt and the amount that you paid for the test(s).

You can use this form if you are a member of any of the following plans:

1. HAP Empowered Medicaid
2. HAP Empowered Dual Special Needs Plan (D-SNP)
3. HAP Empowered MI Health Link Medicare-Medicaid Plan (MMP)

Step 1: Complete the form			
First Name:		Last Name:	
Member ID:		Member Date of Birth:	/ /
Member Phone Number:	( )		
Address:			
City:		State:		ZIP:	
Date of purchase:	/ /	Name of test kit:	
Did you buy:	☐ One test per box ☐ Two tests per box		
Total number of tests bought:			
Please note: We will pay you back for the cost of the test up to a maximum of $12 per test. You are limited to 8 tests per calendar month. HAP cannot pay for your tests that were covered through your health plan or that were free to you.			
Step 2: Include the receipt(s) with this form. Do not staple to the form.			
Step 3: Mail this form and receipt(s) to:			
HAP Empowered Pharmacy ATTN: Pharmacy Reimbursement 2850 West Grand Boulevard Detroit, MI 48202			

Please allow 14 – 21 days for processing.

Questions? Please contact HAP Empowered Customer Service at (888) 654-2200 (TTY: 711), available seven days a week, 24 hours a day.

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