Florida Health Care Plans®

An Independent Licensee of the Blue Cross and Blue Shield Association

Commercial Employer Group and ACA Member Reimbursement

Request Form for Over-the-Counter (OTC) COVID-19 Tests

Complete this form to request reimbursement from FHCP for the purchase of OTC COVID-19 tests. You may be entitled to reasonable reimbursement for eligible OTC COVID-19 Tests. We will cover up to 8 tests every 30 days (Most tests come in kits of two or more tests). Shipping, handling, fees, and other expenses are not reimbursable.

FHCP continues to offer COVID-19 testing at its Extended Hour Care Centers - Members may call (386) 615-4022 for scheduling and locations.

Member Information	
Member Name	
Member Home Address	
DOB	**Member ID Number**
Email	**Phone Number**
Requested COVID-19 Test Information	
Type of Test / Brand	
Place of Purchase	
Date of Purchase	
Purchase Price	

Please provide the following as proof of purchase:

- Original UPC code from the package
- Receipt of purchase
- Completed forms and attached proof of purchase documentation should be sent to:

Florida Health Care Plans
P.O. Box 10348
Daytona Beach, FL 32120-0348

I acknowledge and agree that the test submitted for reimbursement are OTC COVID-19 tests that I purchased at the date, location, and price stated above. I agree and acknowledge that this test is only going to be used for my own personal use. Limitations may apply. I agree and acknowledge that this test will not be used for employment purposes. I agree and acknowledge that I have not been and will not be reimbursed for the submitted test by another source. I agree that I will not resell any test submitted for reimbursement. Incomplete submissions may be denied for reimbursement.

I acknowledge and agree that the information provided is true, complete, and accurate.

_____ _____

Member/Parent or Guardian Signature Date