Direct Member Reimbursement for Covid-19 At-Home Tests

Members may seek reimbursement for at-home Covid-19 test which were purchased out of pocket at pharmacies or other retail and internet sources. Requirements to receive reimbursement:

- That you submit a reimbursement request form (this form) and your receipt(s) to obtain reimbursement.
- Ascend will only reimburse for up to eight (8) FDA authorized at home Covid-19 tests (not 8 boxes/kits) per member per 30 days.
- Since this service is covered under your prescription benefit at in-network pharmacies, Ascend's maximum reimbursement will be $12.50 per test. (You can find an in network pharmacy on Ascend's website www.ascendpbm.com)
- Test purchased before January 15, 2022 will not be reimbursed.
- Request for reimbursement must be within 90 days after the date the test was purchased.

If you have questions, please call Member Services at **833-200-5040.**

INSTRUCTIONS:

Enclose the following

• Please complete the Cardholder information section below OR Provide a copy your prescription benefit card.
• Your Plan Sponsor is your employer or the organization through which you receive benefits.
• Be sure to read the release, sign and date this form.
• Retain copies of all documentation as forms and receipts submitted to ASCENDpbm will not be returned.

Be sure you have completed the form accurately and included the following for each covered member seeking to be reimbursed. You must include a detailed or an itemized receipt containing the following:

• Date of purchase
• Name of Test
• Quantity of Tests
• Name of store purchased

Reimbursement will be according to the parameters of your prescription benefit plan and only for the amount your program would have paid on your behalf. The amount of reimbursement is limited to a maximum of $12.50 per test, not what you actually may have paid per test.

CARDHOLDER INFORMATION			
Cardholder ID#	**RxGrp#**	**Plan Sponsor**	
Cardholder Name	**Phone**	**Date of Birth (MM/DD/YYYY)**	
Cardholder Address	**City**	**State**	**Zip Code**

MEMBER(s) INFORMATION for members seeking reimbursement

Member Name	Date of Birth (MM/DD/YYYY)
Member Name	Date of Birth (MM/DD/YYYY)
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Member Name	Date of Birth (MM/DD/YYYY)
Member Name	Date of Birth (MM/DD/YYYY)

(If there are additional members please use additional forms)

SIGNATURE / RELEASE

By signing this form, you certify that the information provided is accurate and authorize the release of all necessaryinformation to all appropriate parties involved in the administration of this claim. In addition, you certify that all tests being submitted for reimbursement are for individual member use only, will not be resold, and will not be used to meet any employer requirements for weekly testing of non-vaccinated employees.

Signature (Member, Parent or Guardian)	Print Name	Date

EMAIL COMPLETED FORM TO:
HELPDESK@ASCENDPBM.COM

PLEASE NOTE: Keep in mind that communications via email over the internet are not secure. There is a possibility that information you include in an email can be intercepted and read by other parties besides the person to whom it is addressed.

MAIL COMPLETED FORM TO:

ASCENDpbm
ATTN: BILLING
6480 Technology Drive,
Suite A 103
Kalamazoo, MI 49009

FAX COMPLETED FORM TO:
877-326-2856

QUESTIONS?

If you have questions, please contact ASCENDpbm Member Services at:
Phone: 833-200-5040
www.ASCENDpbm.com

Fraud Prevention: Any person who knowingly and with the intent to defraud any insurer or self-insured, presents or causes to be presented to any insurer or self-insured any statement forming a part of, or in support of, a claim that contains any false, incomplete or misleading information concerning any fact or thing material to the claim commits a fraudulent insurance act, which is a crime and subjects such a person to criminal and civil penalties.