



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:	<input type="checkbox"/> One test per box <input type="checkbox"/> 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 Duals (HMO SNP) Customer Service at (800) 848-4844 (TTY: 711), 8 a.m. to 8 p.m., Seven Days a Week (Oct. 1 – March 31) and 8 a.m. to 8 p.m., Monday through Friday (April 1 - Sept. 30).

HAP Empowered Duals (HMO SNP) is a Medicare health plan with a Medicare contract and a contract with Michigan Medicaid Program. Enrollment depends on contract renewal.