The federal government now requires commercial health plans to cover the cost of over-the-counter COVID-19 tests for members beginning January 15, 2022. This policy will remain in effect for the duration of the Federal Public Health Emergency.

As the result of a new requirement announced this week by the Biden-Harris Administration, CareFirst BlueCross BlueShield (CareFirst) will now reimburse members for over-the-counter at-home COVID-19 tests.

We recognize the important role testing, along with vaccines and boosters, has played in the effort to battle the pandemic. Over-the-counter at-home tests have been in limited supply over the last few weeks and finding tests can be challenging. The process we've put in place empowers our members to buy and submit claims for tests purchased through online vendors and retail locations of their choosing.

Member Reimbursement
Commercial members* may receive reimbursement for up to eight over-the-counter COVID-19 at-home tests per covered individual in the household per 30-days without a healthcare provider order or clinical assessment. If multiple tests are sold in one package, i.e., if one package includes two tests, it counts as two tests and not one test package toward the quantity limit.

Tests that can be purchased at a retail location or online but are then sent to a lab for processing are not covered unless accompanied by a doctor's order (except for individuals covered by fully insured plans based in the District of Columbia).

To be eligible for reimbursement, the purchased COVID-19 tests:

- must be purchased on or after January 15, 2022
- must be for personal diagnostic use
    - used to identify the potential COVID-19 infection
    - not be used for employment purposes
    - not used for surveillance testing
- will be self-administered with results that can be self-read
- will not be resold, given or supplied to persons other than family members covered under the same policy
- will not be reimbursed by another source

Claims Submission
Members must complete a claims form and mail it to CareFirst. To print and mail your claim form, log in to My Account; choose the Plan Documents tab, then Forms. Next, select the appropriate form for your claim.

Once you have your claim form:

- Complete and sign the form
- Attach the required documentation
- Mail everything to us according to the directions on the form

Required documentation for this claim includes:

- The purchase receipt documenting the date of purchase and price
- UPC* from the over-the-counter COVID-19 test packaging

- Signed, completed attestation confirming and acknowledging that the purchased over-the-counter at-home COVID-19 test meets eligibility guidelines.

The attestation included in our claims process ensures our members comply with the spirit of this policy—to ensure tests are accessible and affordable for those who need them. Buying tests to store them for a potential need isn't good for the community or public health. We ask everyone to respect and protect community health as the supply chain and our health and retail partners catch up with demand.

Other Testing Options
We are committed to making sure members get the care they need when they need it. CareFirst continues to cover the cost of COVID-19 tests administered by a healthcare provider for diagnostic purposes. Additionally, members may also access free testing in the community. A list of community-based testing sites can be found here.

Learn More

Frequently Asked Questions

--

* This mandate only applies to Commercial Risk, Commercial Non-Risk, Federal Employee Program (FEP) and Federal Employee Health Benefits Program (FEHBP) plan members.

** The UPC (Universal Product Code) is the barcode and 12-digit-number that typically runs below it.

How to submit your claim for an At-Home OTC COVID-19 Test

What Tests are covered? CareFirst will cover any At-Home OTC COVID-19 test that meets federal requirements, which is self-administered, and the results are read by the member. Members may purchase tests at a retail store or online. Tests purchased at a retail location or online then sent to a lab for processing are not covered unless accompanied by a doctor's order (except for residents of plans based in the District of Columbia).

How do I get reimbursed for my at-home test? You must submit the following:

- Claim Form,
- Original receipt,
- The attestation form attached to these instructions; and
- UPC code cut out from each COVID test being submitted. UPC codes should be taped to a sheet of paper.

Example of UPC code: 

Completing the claim form:

The following sections of the claim form must be completed

1. Member ID
2. Group Number or Enrollment Code
3. Patient's Name
4. Patient's Date of Birth
5. Patient's Sex
6. Patient's Relationship to Subscriber
7. Subscriber's Name
9. Subscriber's Address
10. Is Patient Covered Under other Health Insurance (all questions)
16. List Below Only Those Charges Being Claimed
    a. Name of Provider – **Enter location purchased and name of the test**
    b. Description of Services – **Enter "A9150" and number of tests in the unit (box) purchased. If a box contains 2 tests, you will enter – 2 tests; if a box contains a single test, you will enter 1 test**
    c. Diagnosis **– Enter Z11.52**
    d. From Date **– Enter date purchased (from receipt)**
    e. Charge **– Enter the cost of the COVID test(s) purchased** (you may include tax and standard shipping costs. Express, Rush or Overnight Shipping charges will not be reimbursed)
17. Total – **Enter the total charges on the claim**
18. **Sign the claim form either electronically or physically**

Example:

16. LIST BELOW ONLY THOSE CHARGES BEING CLAIMED AND ATTACH ORIGINAL ITEMIZED BILLS FROM THE PROVIDER FOR THESE SERVICES

	NAME(S) OF PROVIDER(S)	DESCRIPTION(S) OF SERVICE(S)	DIAGNOSIS (IF MORE THAN ONE)	FROM DATE	TO DATE	CHARGE
A.	Walmart / BinaxNOW	A9150 - 2 tests	Z11.52	01 / 15 / 22	/ /	$ 24 . 99
B.	RiteAid/iHealth	A9150 - 2 tests	Z11.52	01 / 15 / 22	/ /	$ 20 . 50
C.				/ /	/ /	$.
D.				/ /	/ /	$.

17. TOTAL $ 45 . 49

HEALTH BENEFITS CLAIM FORM

CareFirst BlueChoice

PLEASE COMPLETE A SEPARATE CLAIM FORM FOR EACH FAMILY MEMBER. PLEASE COMPLETE A SEPARATE CLAIM FORM FOR EACH PROVIDER. (SEE REVERSE SIDE FOR FILING INFORMATION)
PLEASE COMPLETE EACH NUMBERED ITEM—FAILURE TO DO SO MAY RESULT IN DELAYS IN PROCESSING YOUR CLAIM

PLEASE TYPE OR PRINT

1. MEMBER ID#	2. GROUP NUMBER OR ENROLLMENT CODE	3. PATIENT'S NAME (FIRST, MIDDLE INITIAL, LAST)

4. PATIENT'S DATE OF BIRTH	5. PATIENT'S SEX	6. PATIENT'S RELATIONSHIP TO SUBSCRIBER:
MO / DAY / YEAR	FEMALE ❑ MALE ○	*EE SP CH* SELF ❑ SPOUSE ○ CHILD ○ OTHER ○ EXPLAIN:

7. SUBSCRIBER'S NAME (FIRST, MIDDLE INITIAL, LAST)	8.DAYTIME TELEPHONE NUMBER (INCLUDE AREA CODE)
	( ) —

9. SUBSCRIBER'S ADDRESS (STREET, CITY, STATE, ZIP CODE) CHECK IF NEW ADDRESS ❑

10. IS PATIENT COVERED UNDER OTHER HEALTH INSURANCE? NO ❑ YES ○ IF YES, NAME OF OTHER INSURANCE COMPANY

NAME OF POLICY HOLDER

POLICY OR IDENTIFICATION NUMBER

IS PATIENT COVERED UNDER MEDICARE? NO ❑ YES ○

IF THE SUBSCRIBER IS MARRIED, IS THE SPOUSE EMPLOYED? NO ❑ YES ○
IF YES, GIVE THE NAME OF THE SPOUSE'S EMPLOYER

IF YES, PART A ❑ PART B ❑ MEDICARE NUMBER

IS PATIENT ACTIVELY EMPLOYED? NO ❑ YES ○ IF YES, NAME OF EMPLOYER

11. WAS PATIENT'S CONDITION DUE TO: AUTO ACCIDENT? NO ❑ YES ○ ANY OTHER ACCIDENTAL INJURY? NO ❑ YES ○ WORK RELATED ACCIDENT OR CONDITION? NO ❑ YES ○
MEDICAL EMERGENCY? NO ❑ YES ○

IF AN ACCIDENT, GIVE THE DATE OF THE ACCIDENT MO / DAY / YEAR

WAS ANOTHER PARTY AT FAULT? NO ❑ YES ○

IF MEDICAL EMERGENCY GIVE DATE SYMPTOMS BEGAN MO / DAY / YEAR

IF YES, ATTACH A STATEMENT WITH DETAILS (SEE ACCIDENTAL INJURY ON THE REVERSE SIDE)

12. WAS PATIENT HOSPITALIZED? NO ❑ YES ❑

ADMISSION DATE MO / DAY / YEAR

IF YES, COMPLETE THE FOLLOWING:

DISCHARGE MO / DAY / YEAR

NAME OF HOSPITAL

NAME & ADDRESS OF ADMITTING PHYSICIAN

13. ARE BILLS FOR A CONSULTATION ATTACHED? NO ❑ YES ○ IF YES, GIVE NAME OF PHYSICIAN WHO REQUESTED THE CONSULTATION

WAS THE CONSULTATION REQUESTED TO OBTAIN A SECOND SURGICAL OPINION? NO ❑ YES ○

WAS SURGERY RECOMMENDED? NO ❑ YES ○

14. ARE BILLS FOR MATERNITY ATTACHED? NO ❑ YES ○ IF YES, WHAT IS THE DATE OF THE LAST MENSTRUAL PERIOD? MO / DAY / YEAR

15. STATE THE DIAGNOSIS, SYMPTOMS, ILLNESS OR INJURY FOR THE EXPENSES CLAIMED

HAS PATIENT HAD THESE SYMPTOMS/CONDITION BEFORE? NO ❑ YES ❑ IF YES, WHEN MO / DAY / YEAR

GIVE DATE SYMPTOM(S) FIRST STARTED MO / DAY / YEAR

GIVE DATE PHYSICIAN FIRST SEEN MO / DAY / YEAR

16. LIST BELOW ONLY THOSE CHARGES BEING CLAIMED AND ATTACH ORIGINAL ITEMIZED BILLS FROM THE PROVIDER FOR THESE SERVICES

	NAME(S) OF PROVIDER(S)	*DESCRIPTION(S) OF SERVICE(S)*	*DIAGNOSIS (IF MORE THAN ONE)*	*FROM DATE*	*TO DATE*	*CHARGE*
A.				MO / DAY / YEAR	MO / DAY / YEAR	$.
B.				/ /	/ /	$.
C.				/ /	/ /	$.
D.				/ /	/ /	$.

17. **TOTAL** $.

18. THIS CLAIM FORM MUST BE SIGNED. IF NOT, IT WILL BE RETURNED.

I request benefits for these expenses and certify that the above information is correct and that the foregoing expenses were incurred for the above named patient. I authorize any physician, nurse, hospital or other providers or suppliers in possession of information concerning the patient to furnish such information to CareFirst BlueChoice, Inc. upon request.

Subscriber Signature

Date MO / DAY / YEAR

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

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS (SEE REVERSE)

I, the undersigned, authorize CareFirst BlueChoice, Inc. to make payment for benefits due herein to

Name of Provider

Provider's Tax or Social Security Number

Name of Provider

Provider's Tax or Social Security Number

Subscriber Signature

Date MO / DAY / YEAR

INSTRUCTIONS

THIS FORM IS TO BE USED TO SUBMIT A CLAIM FOR SERVICES RENDERED UNDER YOUR CAREFIRST BLUECHOICE, INC. HEALTH PLAN. THE BLUECHOICE PROVIDER IS RESPONSIBLE FOR SUBMITTING CLAIMS FOR IN-NETWORK SERVICES. TO AVOID HAVING YOUR CLAIM RETURNED:

- ✓ PREPARE A **SEPARATE CLAIM FORM** FOR EACH FAMILY MEMBER.
- ✓ COMPLETE **ALL OF THE INFORMATION REQUESTED** IN ITEMS 1 THRU 18.
- ✓ IF YOU **PREFER THAT BENEFITS BE PAID TO THE PROVIDER OF SERVICE BE SURE TO COMPLETE THE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS ON THE FRONT.** CAREFIRST BLUECHOICE, INC. RESERVES THE RIGHT TO MAKE PAYMENT DIRECTLY TO THE SUBSCRIBER AND TO REFUSE TO HONOR THE ASSIGNMENT OF ANY CLAIM TO ANY PERSON OR PARTY.

EACH PROVIDER'S ORIGINAL ITEMIZED BILL MUST BE ATTACHED AND CONTAIN:

- ✓ THE LETTERHEAD INDICATING THE NAME AND ADDRESS OF THE PERSON OR ORGANIZATION PROVIDING THE SERVICE
- ✓ THE NAME OF THE PATIENT RECEIVING THE SERVICE
- ✓ THE DATE FOR EACH INDIVIDUAL SERVICE (A RANGE OF DATES CANNOT BE ACCEPTED)
- ✓ THE CHARGE FOR EACH INDIVIDUAL SERVICE
- ✓ A DESCRIPTION OF EACH SERVICE

ON EACH BILL, PLEASE CROSS OUT ANY CHARGES THAT WERE INCLUDED ON A PREVIOUS CLAIM. PERSONAL ITEMIZATIONS, CASH REGISTER RECEIPTS, CREDIT CARD RECEIPTS AND CANCELLED CHECKS ARE NOT ACCEPTABLE. ITEMIZED BILLS CANNOT BE RETURNED.

IN ADDITION TO THE ABOVE REQUIREMENTS, THE FOLLOWING INFORMATION WILL BE NEEDED:

ACCIDENTAL INJURY - STATEMENTS MUST CONTAIN DETAILS AS TO WHEN, WHERE AND THE MANNER IN WHICH THE INJURY OCCURRED, AS WELL AS THE NAME AND ADDRESS OF THE PARTY AT FAULT.

PRESCRIPTION DRUGS - BILLS MUST INCLUDE THE PRESCRIPTION NUMBER, THE NAME OF THE DRUG AND THE NAME OF THE PHYSICIAN PRESCRIBING THE MEDICATION.

PRIVATE DUTY NURSING - BILLS MUST INCLUDE THE SHIFT WORKED, THE CHARGE PER HOUR, THE NUMBER OF HOURS WORKED, THE NURSE'S PROFESSIONAL STATUS, PROFESSIONAL LICENSE NUMBER AND FAMILY RELATIONSHIP TO THE PATIENT, IF ANY. A STATEMENT FROM THE ATTENDING PHYSICIAN MUST ACCOMPANY THE CLAIM. THE STATEMENT SHOULD EXPLAIN THE MEDICAL NECESSITY OF THE SERVICE AND THE AUTHORIZATION FOR IT.

PROSTHETIC APPLIANCES AND THE RENTAL OR PURCHASE OF DURABLE MEDICAL EQUIPMENT - A STATEMENT FROM THE ATTENDING PHYSICIAN MUST ACCOMPANY THE CLAIM. THE STATEMENT SHOULD EXPLAIN THE MEDICAL NECESSITY OF THE EQUIPMENT AND THE PHYSICIAN'S AUTHORIZATION FOR IT.

PSYCHOTHERAPY - BILLS MUST INCLUDE THE LENGTH OF THE SESSION, THE TYPE OF SESSION AND THE PROVIDER'S PROFESSIONAL STATUS. IF THE PROVIDER IS OTHER THAN A MEDICAL DOCTOR, THE PROVIDER'S PROFESSIONAL LICENSE NUMBER MUST ALSO BE GIVEN.

FOR PATIENTS COVERED BY ANOTHER INSURANCE CARRIER OR MEDICARE - IF THE PATIENT IS CLAIMING BENEFITS FOR ANY CHARGES THAT ARE ELIGIBLE FOR BENEFITS UNDER ANY OTHER HEALTH INSURANCE POLICY OR MEDICARE PART A AND/OR PART B, THE EXPLANATION OF BENEFITS FORM FURNISHED BY THE OTHER CARRIER PERTAINING TO THESE CHARGES MUST BE INCLUDED WITH THE ITEMIZED BILLS. A CLEAR PHOTOCOPY OF THE OTHER CARRIER'S EXPLANATION OF BENEFITS FORM IS ACCEPTABLE IN PLACE OF THE ORIGINAL DOCUMENT.

BEFORE SUBMITTING YOUR CLAIM, PLEASE BE SURE THAT:

1. THE CLAIM FORM IS FULLY COMPLETED AND SIGNED.
2. THE ITEMIZED BILLS ARE ATTACHED.
3. YOU HAVE KEPT COPIES OF EACH DOCUMENT AND BILL FOR YOUR PERSONAL RECORDS

THE CLAIM FORM AND ALL RELATED MATERIALS SHOULD BE SUBMITTED TO:

CAREFIRST BLUECHOICE, INC.
MAIL ADMINISTRATOR
P.O. BOX 14116
LEXINGTON, KY 40512-4116

CareFirst
Family of health care plans

Notice of Nondiscrimination and Availability of Language Assistance Services

CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc. and all of their corporate affiliates (CareFirst) comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. CareFirst does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

CareFirst:

- Provides free aid and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please call 855-258-6518.

If you believe CareFirst has failed to provide these services, or discriminated in another way, on the basis of race, color, national origin, age, disability or sex, you can file a grievance with our CareFirst Civil Rights Coordinator by mail, fax or email. If you need help filing a grievance, our CareFirst Civil Rights Coordinator is available to help you.

To file a grievance regarding a violation of federal civil rights, please contact the Civil Rights Coordinator as indicated below. Please do not send payments, claims issues, or other documentation to this office.

Civil Rights Coordinator, Corporate Office of Civil Rights

Mailing Address	P.O. Box 8894 Baltimore, Maryland 21224
Email Address	**civilrightscoordinator@carefirst.com**
Telephone Number	410-528-7820
Fax Number	410-505-2011

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf** or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

REV. (12/17)

Foreign Language Assistance

Attention (English): This notice contains information about your insurance coverage. It may contain key dates and you may need to take action by certain deadlines. You have the right to get this information and assistance in your language at no cost. Members should call the phone number on the back of their member identification card. All others may call 855-258-6518 *and wait through the dialogue until prompted to push* 0. *When an agent answers, state the language you need and you will be connected to an interpreter.*

አማርኛ(Amharic) ማሳሰቢያ፦ ይህ ማስታወቂያ ስለ መድን ሽፋንዎ መረጃ ይዟል። ከተወሰኑ ቀነ-ገደቦች በፊት ሊፈጽሟቸው የሚገቡ ነገሮች ሊኖሩ ስለሚችሉ እነዚህን ወሳኝ ቀናት ሊይዝ ይችላል። ይኽን መረጃ የማግኘት እና ያለምንም ክፍያ በቋንቋዎ እገዛ የማግኘት መብት አለዎት። አባል ከሆኑ ከመታወቂያ ካርድዎ በስተጀርባ ላይ ወደተጠቀሰው የስልክ ቁጥር መደወል ይችላሉ። አባል ካልሆኑ ደግሞ ወደ ስልክ ቁጥር 855-258-6518 ደውለው 0ን እንዲጫኑ እስኪነገርዎ ድረስ ንግግሩን መጠበቅ አለብዎ። አንድ ወኪል መልስ ሲሰጥዎ፣ የሚፈልጉትን ቋንቋ ያሳውቁ፣ ከዚያም ከተርጓሚ ጋር ይገናኛሉ።

Èdè Yorùbá (Yoruba) Ìtẹ́tíléko: Àkíyèsí yìí ní ìwífún nípa iṣẹ́ adójútòfò rẹ. Ó le ní àwọn déètì pàtó o sì le ní láti gbé ìgbésẹ̀ ní àwọn ọjọ́ gbèdéke kan. O ni ẹ̀tọ́ láti gba ìwífún yìí àti ìrànlọ́wọ́ ní èdè rẹ lọ́fẹ̀ẹ́. Àwọn ọmọ-ẹgbẹ́ gbọ́dọ̀ pe nọ́mbà fóònù tó wà lẹ́yìn káàdì ìdánimọ̀ wọn. Àwọn míràn le pe 855-258-6518 kí o sì dúró nípasẹ̀ ìjíròrò tití a ó fi sọ fún ọ láti tẹ 0. Nígbàtí aṣojú kan bá dáhùn, sọ èdè tí o fẹ́ a ó sì so ọ́ pọ̀ mọ́ ògbufọ̀ kan.

Tiếng Việt (Vietnamese) Chú ý: Thông báo này chứa thông tin về phạm vi bảo hiểm của quý vị. Thông báo có thể chứa những ngày quan trọng và quý vị cần hành động trước một số thời hạn nhất định. Quý vị có quyền nhận được thông tin này và hỗ trợ bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Các thành viên nên gọi số điện thoại ở mặt sau của thẻ nhận dạng. Tất cả những người khác có thể gọi số 855-258-6518 và chờ hết cuộc đối thoại cho đến khi được nhắc nhấn phím 0. Khi một tổng đài viên trả lời, hãy nêu rõ ngôn ngữ quý vị cần và quý vị sẽ được kết nối với một thông dịch viên.

Tagalog (Tagalog) Atensyon: Ang abisong ito ay naglalaman ng impormasyon tungkol sa nasasaklawan ng iyong insurance. Maaari itong maglaman ng mga pinakamahalagang petsa at maaaring kailangan mong gumawa ng aksyon ayon sa ilang deadline. May karapatan ka na makuha ang impormasyong ito at tulong sa iyong sariling wika nang walang gastos. Dapat tawagan ng mga Miyembro ang numero ng telepono na nasa likuran ng kanilang identification card. Ang lahat ng iba ay maaaring tumawag sa 855-258-6518 at maghintay hanggang sa dulo ng diyalogo hanggang sa diktahan na pindutin ang 0. Kapag sumagot ang ahente, sabihin ang wika na kailangan mo at ikokonekta ka sa isang interpreter.

Español (Spanish) Atención: Este aviso contiene información sobre su cobertura de seguro. Es posible que incluya fechas clave y que usted tenga que realizar alguna acción antes de ciertas fechas límite. Usted tiene derecho a obtener esta información y asistencia en su idioma sin ningún costo. Los asegurados deben llamar al número de teléfono que se encuentra al reverso de su tarjeta de identificación. Todos los demás pueden llamar al 855-258-6518 y esperar la grabación hasta que se les indique que deben presionar 0. Cuando un agente de seguros responda, indique el idioma que necesita y se le comunicará con un intérprete.

Русский (Russian) Внимание! Настоящее уведомление содержит информацию о вашем страховом обеспечении. В нем могут указываться важные даты, и от вас может потребоваться выполнить некоторые действия до определенного срока. Вы имеете право бесплатно получить настоящие сведения и сопутствующую помощь на удобном вам языке. Участникам следует обращаться по номеру телефона, указанному на тыльной стороне идентификационной карты. Все прочие абоненты могут звонить по номеру 855-258-6518 и ожидать, пока в голосовом меню не будет предложено нажать цифру «0». При ответе агента укажите желаемый язык общения, и вас свяжут с переводчиком.

हिन्दी (Hindi) ध्यान दें: इस सूचना में आपकी बीमा कवरेज के बारे में जानकारी दी गई है। हो सकता है कि इसमें मुख्य तिथियों का उल्लेख हो और आपके लिए किसी नियत समय-सीमा के भीतर काम करना ज़रूरी हो। आपको यह जानकारी और संबंधित सहायता अपनी भाषा में निःशुल्क पाने का अधिकार है। सदस्यों को अपने पहचान पत्र के पीछे दिए गए फ़ोन नंबर पर कॉल करना चाहिए। अन्य सभी लोग 855-258-6518 पर कॉल कर सकते हैं और जब तक 0 दबाने के लिए न कहा जाए, तब तक संवाद की प्रतीक्षा करें। जब कोई एजेंट उत्तर दे तो उसे अपनी भाषा बताएँ और आपको व्याख्याकार से कनेक्ट कर दिया जाएगा।

Bǎsɔ́ɔ̀-wùdù (Bassa) Tò Đùǔ Cáo! Bɔ̌ nìà kɛ ɓá nyɔ ɓě ké m̀ gbo kpá ɓó nì fǔà-fǔá-tìǐn nyɛɛ jè dyí. Bɔ̌ nìà kɛ ɓédɖé wé jɛ́ɛ́ ɓě ɓɛ́ m̀ ké dɛ wa mó m̀ ké nyuɛɛ nyu hwè ɓɛ́ wé ɓěa ké zi. Ɔ mò nì kpé ɓɛ́ m̀ ké bɔ̌ nìà kɛ kè gbo-kpá-kpá m̀ mɔ́ɛɛ dyé dɖé nì ɓídɖí-wùdù mú ɓɛ́ m̀ ké se wídɖí dɔ̀ pɛ́è. Kpooɔ̀ nyɔ ɓě mɛ dɖá fǔùn-nɔ̀ɓà nìà dɖé waà I.D. káàɔ̀ dɛín nyɛ. Nyɔ tɔ̀ɔ̀ séín mɛ dɖá nɔ̀ɓà nìà kɛ: 855-258-6518, ké m̀ mɛ fò tee ɓɛ́ wa kéɛ m̀ gbo cɛ̃ ɓɛ́ m̀ ké nɔ̀ɓà mɔà 0 kɛɛ dyi pàdɖàìn hwè. Ɔ jǔ ké nyɔ dɔ̀ dyi m̀ gɔ̌ jǔǐn, po wudu m̀ mɔ́ poɛ dyiɛ, ké nyɔ dɔ̀ mu ɓó nììn ɓɛ́ ɔ ké nì wudɔ̀ mú zà.

বাংলা (Bengali) লক্ষ্য করুন: এই নোটিশে আপনার বিমা কভারেজ সম্পর্কে তথ্য রয়েছে। এর মধ্যে গুরুত্বপূর্ণ তারিখ থাকতে পারে এবং নির্দিষ্ট তারিখের মধ্যে আপনাকে পদক্ষেপ নিতে হতে পারে। বিনা খরচে নিজের ভাষায় এই তথ্য পাওয়ার এবং সহায়তা পাওয়ার অধিকার আপনার আছে। সদস্যদেরকে তাদের পরিচয়পত্রের পিছনে থাকা নম্বরে কল করতে হবে। অন্যেরা 855-258-6518 নম্বরে কল করে 0 টিপতে না বলা পর্যন্ত অপেক্ষা করতে পারেন। যখন কোনো এজেন্ট উত্তর দেবেন তখন আপনার নিজের ভাষার নাম বলুন এবং আপনাকে দোভাষীর সঙ্গে সংযুক্ত করা হবে।

اردو (Urdu) توجہ :یہ نوٹس آپ کے انشورینس کوریج سے متعلق معلومات پر مشتمل ہے۔ اس میں کلیدی تاریخیں ہو سکتی ہیں اور ممکن ہے کہ آپ کو مخصوص آخری تاریخوں تک کارروائی کرنے کی ضرورت پڑے۔ آپ کے پاس یہ معلومات حاصل کرنے اور بغیر خرچہ کیے اپنی زبان میں مدد حاصل کرنے کا حق ہے۔ ممبران کو اپنے شناختی کارڈ کی پشت پر موجود فون نمبر پر کال کرنی چاہیے۔ سبھی دیگر لوگ 855-258-6518پر کال کر سکتے ہیں اور 0 دبانے کو کہے جانے تک انتظار کریں۔ ایجنٹ کے جواب دینے پر اپنی مطلوبہ زبان بتائیں اور مترجم سے مربوط ہو جائیں گے۔

فارسی (Farsi) توجه: این اعلامیه حاوی اطلاعاتی درباره پوشش بیمه شما است. ممکن است حاوی تاریخ های مهمی باشد و لازم است تا تاریخ مقرر شده خاصی اقدام کنید. شما از این حق برخوردار هستید تا این اطلاعات و راهنمایی را به صورت رایگان به زبان خودتان دریافت کنید. اعضا باید با شماره درج شده در پشت کارت شناسایی‌شان تماس بگیرند. سایر افراد می توانند با شماره 855-258-6518تماس بگیرند و منتظر بمانند تا از آنها خواسته شود عدد 0 را فشار دهند. بعد از پاسخگویی توسط یکی از اپراتورها، زبان مورد نیاز را تنظیم کنید تا به مترجم مربوطه وصل شوید.

اللغة العربية (Arabic) تنبيه :يحتوي هذا الإخطار على معلومات بشأن تغطيتك التأمينية، وقد يحتوي على تواريخ مهمة، وقد تحتاج إلى اتخاذ إجراءات بحلول مواعيد نهائية محددة .يحق لك الحصول على هذه المساعدة والمعلومات بلغتك بدون تحمل أي تكلفة .ينبغي على الأعضاء الاتصال على رقم الهاتف المذكور في ظهر بطاقة تعريف الهوية الخاصة بهم .يمكن للآخرين الاتصال على الرقم 855-258-6518 والانتظار خلال المحادثة حتى يطلب منهم الضغط على رقم .0 عند إجابة أحد الوكلاء، اذكر اللغة التي تحتاج إلى التواصل بها وسيتم توصيلك بأحد المترجمين الفوريين.

中文繁体 (Traditional Chinese) 注意：本聲明包含關於您的保險給付相關資訊。本聲明可能包含重要日期及您在特定期限之前需要採取的行動。您有權利免費獲得這份資訊，以及透過您的母語提供的協助服務。會員請撥打印在身分識別卡背面的電話號碼。其他所有人士可撥打電話 855-258-6518，並等候直到對話提示按下按鍵 0。當接線生回答時，請說出您需要使用的語言，這樣您就能與口譯人員連線。

Igbo (Igbo) Nrụbama: Ọkwa a nwere ozi gbasara mkpuchi nchekwa onwe gị. Ọ nwere ike ịnwe ụbọchị ndị dị mkpa, ị nwere ike ịme ihe tupu ụfọdụ ụbọchị njedebe. Ị nwere ikike ịnweta ozi na enyemaka a n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ndị otu kwesịrị ịkpọ akara ekwentị dị n'azụ nke kaadị njirimara ha. Ndị ọzọ niile nwere ike ịkpọ 855-258-6518 wee chere ụbụbọ ahụ ruo mgbe amanyere ịpị 0. Mgbe onye nnọchite anya zara, kwuo asụsụ ị chọrọ, a ga-ejikọ gị na onye ọkọwa okwu.

Deutsch (German) Achtung: Diese Mitteilung enthält Informationen über Ihren Versicherungsschutz. Sie kann wichtige Termine beinhalten, und Sie müssen gegebenenfalls innerhalb bestimmter Fristen reagieren. Sie haben das Recht, diese Informationen und weitere Unterstützung kostenlos in Ihrer Sprache zu erhalten. Als Mitglied verwenden Sie bitte die auf der Rückseite Ihrer Karte angegebene Telefonnummer. Alle anderen Personen rufen bitte die Nummer 855-258-6518 an und warten auf die Aufforderung, die Taste 0 zu drücken. Geben Sie dem Mitarbeiter die gewünschte Sprache an, damit er Sie mit einem Dolmetscher verbinden kann.

Français (French) Attention: cet avis contient des informations sur votre couverture d'assurance. Des dates importantes peuvent y figurer et il se peut que vous deviez entreprendre des démarches avant certaines échéances. Vous avez le droit d'obtenir gratuitement ces informations et de l'aide dans votre langue. Les membres doivent appeler le numéro de téléphone figurant à l'arrière de leur carte d'identification. Tous les autres peuvent appeler le 855-258-6518 et, après avoir écouté le message, appuyer sur le 0 lorsqu'ils seront invités à le faire. Lorsqu'un(e) employé(e) répondra, indiquez la langue que vous souhaitez et vous serez mis(e) en relation avec un interprète.

한국어(Korean) 주의: 이 통지서에는 보험 커버리지에 대한 정보가 포함되어 있습니다. 주요 날짜 및 조치를 취해야 하는 특정 기한이 포함될 수 있습니다. 귀하에게는 사용 언어로 해당 정보와 지원을 받을 권리가 있습니다. 회원이신 경우 ID 카드의 뒷면에 있는 전화번호로 연락해 주십시오. 회원이 아니신 경우 855-258-6518 번으로 전화하여 0을 누르라는 메시지가 들릴 때까지 기다리십시오. 연결된 상담원에게 필요한 언어를 말씀하시면 통역 서비스에 연결해 드립니다.

Diné Bizaad *(Navajo)* Ge': Díí bee ił hane'ígíí bii' dahólǫ bee éédahózin béeso ách'ą́ąh naanil ník'ist'i'ígíí bá. Bii' dahólǫ́ǫ doo íiyisíí yoolkáálígíí dóó t'áádoo le'é ádadoolyíįlígíí da yókeedgo t'áá doo bee e'e'aahí ájiil'íįh. Bee ná ahóót'i' díí bee ił hane' dóó niká'ádoowoł t'áá nínizaad bee t'áá jiik'é. Atah danilínígíí béésh bee hane'é bee wółta'ígíí nitł'izgo bee nee hódolzinígíí bikéédęę' bikáá' bich'į' hodoonihjį'. Aadóó náánáła' éí kojį' dahódoolnih 855-258-6518 dóó yii diiłts'įįł yałtí'ígíí t'áá níléíjį ádóó éí bikéé'dóó naasbąąs bił adidiilchił. Áká'ánidaalwó'ígíí neidiitą́ągo, saad bee yániłt'i'ígíí yii diikił dóó ata' halne'é lá níká'ádoolwoł.

Attestation Statements for OTC At-Home Rapid Antigen COVID Tests

Member ID: _____ Patient Name: _____

Under a requirement of the federal government, CareFirst BlueCross BlueShield (CareFirst) will now reimburse members for over-the-counter (OTC), at-home COVID-19 tests. **The federal mandate only applies to tests purchased to identify potential COVID-19 infection.** OTC COVID-19 tests used for surveillance testing and employment purposes are not covered.

Please initial each item below and attach this document to your claim form.

____ I agree that the expenses for the OTC at-home COVID-19 test(s) are correct and were incurred by the above-named member.

____ I agree that the OTC at-home COVID-19 test(s) was purchased on or after January 15, 2022.

____ I agree that the purchase of the OTC at-home COVID-19 test(s) listed above are not for surveillance, or for the purposes of my employment. (e.g., satisfying an employer's requirement to test weekly).

____ I agree that the expenses listed on the claim form for the OTC at-home COVID-19 test(s) have not been, nor will they be, reimbursed from another source, including employer, school, HSA/FSA or other insurer.

____ I agree that I will not resell, give or supply the OTC at-home COVID-19 Test(s) to any other persons or entities other than my family members covered by the same CareFirst policy.