Contra Costa Health Plan (CCHP)
Plan A, Plan B, Plan A2, IHSS Plan A2

How to get an At-Home COVID Test

Our instructions may change. Please return to our website to check for any updates.

The information below only applies to CCHP Plan A, Plan B, Plan A2, and IHSS Plan A2 members. (Medi-Cal members should call Medi-Cal Rx at 1-800-977-2273 for information.)

Starting January 15, 2022, CCHP will cover up to 8 At-Home COVID Tests per member within a 30 day period. (Keep in mind, some packages contain more than one test, so check how many there are in the box before you decide how many you will buy.)

You can get the At-Home COVID test from one of our **contracted pharmacies** in the CCHP network at **no up-front cost**. *Just show your CCHP ID card at the pharmacy counter and the pharmacist can bill these tests to CCHP.*

If you purchase an At-Home COVID Test at a pharmacy, and the pharmacy is unable to process payment using your insurance information, you can either:

a) Have the pharmacist call the CCHP pharmacy department if they are having issues getting claims to go through
OR
b) Submit a reimbursement request to CCHP.

You can get reimbursed up to the maximum allowable amount per federal regulations (i.e., up to $12 per test). This means CCHP reimbursement might not cover the full cost of what you pay out of pocket.

To get reimbursed, please mail the following to us:

1) **A completed *CCHP At-Home COVID Test Reimbursement Form* (for each CCHP member in your household requesting reimbursement)**

2) **A copy of the receipt(s)**

3) **The box for each test. Please include the part of the box that includes the UPC bar code AND the number of tests included in the box.**

Mail it to:

Contra Costa Health Plan
Attn: At-Home COVID Test Reimbursement
595 Center Ave Ste 100
Martinez, CA 94553

Last Updated: 6/17/2022

CCHP At-Home COVID Test Reimbursement Form

Plan A, Plan B, Plan A2, IHSS Plan A2

Last Name	
First Name	
Date of Birth (mm/dd/yyyy)	**CCHP ID Number** (number on your CCHP ID card)
Home Address	
Mailing Address List only if different from Home Address above	

Purchase Date(s)	# of Tests per Box	# of Boxes Purchased	Amount Paid per Box	Total Amount Paid on Purchase Date
Example: 1/17/2022	*2*	*3*	*$20*	*$60*

Did you purchase the test(s) for personal use? ❒ Yes ❒ No

Are you using or have you used any of these tests for employment purposes? ❒ Yes ❒ No

Have you been reimbursed for this purchase by any other source? ❒ Yes ❒ No

Do you agree not to resell the test? ❒ Yes ❒ No

_____ _____

Signature (***Please sign to attest that all the above is true)*** **Date**

If you are not the member on the form, print your name and tell us your relationship to the member.

_____ _____

First & Last Name (please print) **Relationship to Member**

⚠ **Remember to include your receipt(s) and boxes showing number of tests & UPC bar codes!**