Application for COVID-19 Testing Coverage

What is COVID-19 Testing Coverage?

This coverage provides limited services related to the testing and diagnosis of Coronavirus (COVID-19) and outpatient prescription drug treatment. Testing related services do not include services for treatment of COVID-19.

Who can qualify for COVID-19 Testing Coverage?

You may qualify for COVID-19 Testing Coverage if:

- You are a West Virginia resident;
- You are a U.S. citizen, U.S. national, or eligible immigrant; and
- You are uninsured:
    - Not enrolled in full West Virginia Medicaid or the West Virginia Children's Health Insurance Program
    - Not enrolled in another health care program funded by the federal government, including: Medicare, TRICARE, Veterans Administration, and federal employee health plans; and
    - Not enrolled in a group health plan, private health plan, or other employer-based health insurance coverage.

There is no income or asset test, however an attestation regarding uninsured status is required.

How can I apply for COVID-19 Testing Coverage

You can apply for the COVID-19 Testing Coverage by completing and signing the application on Page 2. All sections of this application must be completed to determine your eligibility to receive coverage. If additional information is needed to make a COVID-19 Testing Coverage determination, we will contact you. If you meet the COVID-19 Testing Coverage requirements, you will receive a notice of eligibility at the home address you provide on the application. The West Virginia COVID-19 Testing Coverage may also include temporary prescription assistance for COVID-19 to help with the cost of any required prescription medication.

The eligibility guidelines for the COVID-19 Testing Coverage can be found at: https://dhhr.wv.gov/bcf/Services/familyassistance/Documents/Binder4.pdf

If you are sick and suspect that you may need testing for COVID-19, you should seek immediate medical attention for evaluation. You can do this by making an appointment with your regular physician, or by seeking care at an urgent care facility, or the nearest hospital emergency room.

Where can I return the application?

You or your provider can submit the application along with the claim for your testing related visit to:

Gainwell Technologies
Attn: COVID-19 Testing
PO BOX 2002
Charleston, WV 25327-2002

Paper claims submissions only.

Application for COVID-19 Testing Coverage

1. Tell us about yourself **(All fields are required)**

Name *(first, middle, last)* ☐ Male ☐ Female

Social Security Number | Date of birth | Phone number

Home address | City | State | Zip Code

County | Mailing address (if different from home address)

2. Other Applicant Information **(All fields are required)**

Do you live in West Virginia and intend to remain? ☐ Yes ☐ No

If no, please provide additional information on where you live or will live?

Are you a U.S. citizen, U.S. National, or an eligible immigrant? ☐ Yes ☐ No

If no, please provide additional information on your U.S. citizenship status below.

Do you have any health care coverage or insurance identified on page one for yourself? ☐ Yes ☐ No

If yes, please provide additional information on your health care coverage or insurance below.

Does anyone else have health care coverage or insurance for you? This could include a parent or spouse. ☐ Yes ☐ No

If yes, please provide additional information on your health care coverage or insurance below.

If you have been tested for COVID-19 in the past, please provide the date(s) of the test.

Date(s): _____ _____

If you are a provider signing this application on behalf of the applicant, please check here: ☐ *Authorized Provider Representative*

*Please provide consent form and/or proof of designation along with this application **or** complete the following:*
Applicant:_____ gave verbal permission on [date/time]_____for [provider]_____ to complete and sign this application on their behalf.

Signature (Required)

By signing, under penalty of perjury, you hereby attest that the information on this form is true and accurate. I know that I may be subject to penalties under federal law if I provide false and/or untrue information. If you are determined to be otherwise eligible for coverage, you authorize DHHR the right to pursue and collect payments from other health insurance, legal settlements, or other third parties for services that were paid by Medicaid.

Your signature: | Date:

WEST VIRGINIA Department of Health & Human Resources

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact your local DHHR office. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)

2. Address	3. Apartment or suite number

4. City	5. State	6. Zip code

7. Phone number ( )

8. Organization name	ID number (if applicable)

9. By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.

10. Your signature	11. Date (mm/dd/yyyy)

For certified application counselors, navigators, agents, and brokers only.

Complete this section if you're a certified application counselor, navigator, agent or broker filling out this application for someone else.

1. Application start date (mm/dd/yyyy)

2. First name, Middle name, Last name & Suffix

3. Organization name	ID number (if applicable)