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 eligible for 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. 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:

DXC Technology, Inc.
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

Name *(first, middle, last)*

☐ Male ☐ Female

Social Security Number | Date of birth | Phone number

Home address

City | State | ZIP code

Mailing address *(if different from home address)*

2. Other Applicant Information

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.

Signature

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: