BlueCross BlueShield of Western New York

PHARMACY COVID-19 TESTING ROSTER

This form should only be used for submitting new claims for COVID-19 testing.

Email completed form to: **Front.End.Submissions@bcbswny.com**

Or mail to:
BlueCross BlueShield of Western New York
ATTN: Corporate Claims Manager
PO Box 80
Buffalo, NY 14240

Member Last Name:	**Member First Name:**	
Member Street Address: **City:** **State:** **ZIP:**		
Member ID (including prefix):	**Member DOB:**	**Date of Service:**
Ordering Provider:	**Servicing Provider:**	
Servicing Provider Street Address: **City:** **State:** **ZIP:**		
Servicing Provider Tax ID:	**Charge:**	

Professional Service Provided (check one):	
	COVID-19 Specimen Collection Only (procedure code 99001)
	COVID-19 Specimen Collection and Testing Analysis (rapid test)
For Rapid Testing, Indicate the Type of Analysis Performed (check one):	
	Detection of COVID-19 antigen by direct visual observation (procedure code 87811)
	Detection of COVID-19 antigen by automated analyzer (procedure code 87426)
Reason for Testing (check all that apply):	
	Patient is experiencing symptoms of COVID-19 (diagnosis code Z11.52)
	Potential exposure to an individual known to have a documented SARS-CoV-2 infection (diagnosis code Z20.822, if date of service is before 1/1/21, use diagnosis code Z20.828)
	Targeted group screening if attended a gathering of more than 10 people (diagnosis code Z11.52)
	Testing for general population, travel, or return to/continued on-site work or school screening for SARS-CoV-2 (diagnosis code Z11.52)
	Other:

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