

Client Name

Client Address where to submit claims

*** * * Over The Counter (OTC) COVID-19 Test - Claim Form * * ***

Participant Information

Print Participant's Last Name		First Name	OEF Number or SSN	
Address Street Number		City	State	Zip
Primary Telephone Number	Email Address			

- Enter the total reimbursement amount for each family member on the lines below.
- Include detailed receipt showing the brand name of the COVID-19 test kit, the number of tests included in each kit, and the amount paid.
- If a detailed receipt is not available, please send the cash register receipt with the original UPC code from each box purchased from a retailer or on-line retailer.
- Only FDA approved tests will be reimbursed. See list on the back side of this form.
- No more than 8 tests per calendar month per eligible family member will be reimbursed when the over the counter tests are purchased from pharmacies, in-person retail businesses, or on-line retail businesses.

Over The Counter (OTC) COVID-19 Test Expense Total Per Person

Relationship	Print Name (First and Last)	Number of COVID-19 Tests (not kits)	Total Amount Per Person
Participant			\$
Spouse			\$
Child (1)			\$
Child (2)			\$
TOTAL CLAIM AMOUNT			\$

Participant Authorization (this form must be signed or it will be returned)

By signing below, I certify that the COVID-19 tests for which reimbursement is requested on this form were purchased by a covered participant or beneficiary for personal use, not for employment purposes, and will not be reimbursed by another source or resold. I understand that I alone am fully responsible for the sufficiency, accuracy, and truthfulness of all information relating to the claims on this form.

Participant's Signature

Date

** this form must be signed or it will be returned **

Over The Counter (OTC) COVID-19 Test Reimbursement

Reimbursement of the cost of Over The Counter (OTC) COVID-19 tests is effective for FDA approved tests purchased on or after January 15, 2022 and until the mandate for coverage from the Biden Administration ends.

To receive reimbursement for eligible expenses, you must submit this written claim form, with the required supporting documentation, to the Fund Office in accordance with the Plan's claim procedures as briefly described here and in more detail in your Summary Plan Description.

Below is a sample list of the FDA approved tests that are eligible for reimbursement from the Fund as of January 2022.

- ❖ Abbott Diagnostics Scarborough, Inc. BinaxNOW tests
 - BinaxNOW COVID-19 Antigen Self Test
 - BinaxNOW COVID-19 Ag Card Home Test
 - BinaxNOW COVID-19 Ag Card 2 Home Test
- ❖ Access Bio, Inc. - CareStart COVID-19 Antigen Home Test
- ❖ ACON Laboratories, Inc - Flowflex COVID-19 Antigen Home Test
- ❖ Becton, Dickinson and Company (BD) - BD Veritor At-Home COVID-19 Test
- ❖ Celltrion USA, Inc. - Celltrion DiaTrust COVID-19 Ag Home Test
- ❖ Cue Health Inc. - Cue COVID-19 Test for Home and Over The Counter (OTC) Use
- ❖ Detect, Inc. - Detect Covid-19 Test
- ❖ Ellume Limited – Ellume COVID-19 Home Test
- ❖ iHealth Labs, Inc. - iHealth COVID-19 Antigen Rapid
- ❖ InBios International Inc.
- ❖ Lucira Health, Inc.
 - Lucira CHECK-IT COVID-19 Test Kit
 - Lucira COVID-19 All-In-One Test Kit (Prescription)
- ❖ OraSure Technologies, Inc.
 - InteliSwab COVID-19 Rapid Test
 - InteliSwab COVID-19 Rapid Test Rx
- ❖ Quidel Corporation
 - QuickVue At-Home OTC COVID-19 Test
 - QuickVue At-Home COVID-19 Test

Send claims to: Health Fund Name
 PO Box 3459
 Farmington Hills, MI 48333