COVID-19 Over-the-Counter at-home Antigen Test reimbursement request form

Use this form to request reimbursement for FDA-approved, at-home over-the-counter antigen tests. A separate form for each member is required. Purchases of 8 individual tests per covered individual per month are eligible for reimbursement.

You must also submit the following documentation to be eligible for reimbursement

- **A receipt -** must show the date of purchase and purchase amount for each testing kit bought; and
- **A picture of the front of the box-** must clearly show the brand name of the testing kit(s)

Member information

Member ID: _____

Member last name	**First name**	**Middle initial**

Date(s) of purchase (purchase date must be on or after January 15, 2022)	**Quantity**	**Total purchase amount**

Describe the test kit(s)

Please select the product/brand of OTC at-home test kit you purchased (select all that apply):

- ☐ BinaxNOW COVID-19 Antigen Self-Test (Abbott)
- ☐ COVID-19 At-Home Test (SD Biosensor)
- ☐ CLINITEST Rapid COVID-19 Antigen Self-Test (Siemens)
- ☐ iHealth COVID-19 Antigen Rapid Test (iHealth Labs)
- ☐ CareStart COVID-19 Antigen Home Test (Access Bio) BD
- ☐ Veritor At-Home COVID-19 Test (Becton Dickinson) SCoV-2
- ☐ Ag Detect Rapid Self-Test (InBios)
- ☐ InteliSwab COVID-19 Rapid Test (OraSure)
- ☐ Celltrion DiaTrust COVID-19 Ag Home-Test (Celltrion)
- ☐ QuickVue At-Home OTC COVID-19 Test (Quidel)
- ☐ Flowflex COVID-19 Antigen Home Test (ACON) Ellume
- ☐ COVID-19 Home Test (Ellume)
- ☐ On/go COVID Kit Antigen (Access Bio)
- ☐ OTC Antigen Kit 1-pack (CVS Pharmacy)
- ☐ Other (include brand and name of test kit below)

_____

Customer attestation

Please check yes or no for **all** of the following questions.

The over-the-counter test kit submitted for reimbursement on this form:

- ☐ Yes ☐ No Was purchased for employment purposes (If yes, STOP; this test is not eligible for reimbursement)
- ☐ Yes ☐ No Was purchased by the customer for personal use or the use of a covered plan member
- ☐ Yes ☐ No Has been (or will be) reimbursed by another source
- ☐ Yes ☐ No Has been (or will be) placed for resale

AR BENEFITS

Certification

☐ By submitting a manual claim for reimbursement of an Over the Counter COVID-19 test, the member is attesting that it was purchased for personal use, not for employment purposes, and will not be reimbursed by another source or used for resale.

☐ I acknowledge that any person who knowingly and with intent to defraud any insurance company or other person by (1) filing an application for insurance or statement of claim containing any materially false information; or (2) concealing for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act, which is a crime and may be subject to fines and confinement in prison.

Signature	**Date signed** (mm/dd/yyyy)

Return to:
Employee Benefits Division
ATTN: Claims
P.O. Box 15610
Little Rock, Arkansas 72231