LOCAL 99 Health & Welfare Fund

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COVID-19 Over the Counter at Home Testing Member Reimbursement Form

Note: A separate claim form must be submitted for each covered individual seeking reimbursement for COVID-19 at home tests under the plan.

To be eligible, the following criteria must apply to each COVID-19 at-home test purchased:

- The at-home test must be authorized by the U.S. Food and Drug Administration (FDA) and approved for use under the Emergency Use Authorization (EUA).
- The COVID-19 OTC test(s) must be purchased on or after 01/15/2022 through the end of the COVID-19 Federal Public Health Emergency (PHE) as determined by the Secretary of Health and Human Services.
- You have enclosed the original receipt, which includes the date of purchase, item purchased, quantity purchased, cost per item, and total paid.
- The at-home test(s) must be purchased on a date when the patient has active coverage.
- Total tests reimbursed does not exceed eight (8) per covered individual per month.

Cardholder/Subscriber Information **Use your BeneCard Pharmacy ID Card to obtain the following information*		
Cardholder ID Number	**Rx Group Number**	**Plan Sponsor**
		Local 99 Health & Welfare Fund
Name	**Daytime Phone Number**	**Email Address**
Street Address		
City	State	Zip Code

Patient Information	
Patient Name	**Relationship to Cardholder**
	☐ Self
Patient Date of Birth	☐ Spouse
	☐ Child
Patient/Parent/Guardian Phone Number	☐ Other ____________________

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Required Claim Information **Include the original receipt with this form. Keep a copy of all documents for your records.*	
Date of Purchase (MM/DD/YYYY)	
Name of COVID-19 At-Home Test	
Universal Product Code (UPC)	
Location Where Test Was Purchased	
Number of Boxes Purchased	
Cost Per Box	
Number of Tests Per Box	

Attestation and Release

By signing this form, you certify the following:

- That the COVID-19 Over-the-Counter Test(s) purchased by the member is for personal use, is not for employment purposes, has not been (and will not be) reimbursed by another source, and is not for resale.
- That the information provided is accurate.

In addition, you authorize the release of all necessary information to all appropriate parties involved in the administration of this claim.

Signature	**Date**

Reimbursement of submitted claims is subject to your prescription benefit program and not guaranteed. Reimbursement will be according to the parameters of your prescription benefit plan and only for the amount your program would have paid on your behalf. The amount of reimbursement may be significantly lower than the original amount you paid.

Fraud Prevention: Any person who knowingly and with the intent to defraud any insurer or self-insured, presents or causes to be presented to any insurer or self-insured any statement forming a part of, or in support of, a claim that contains any false, incomplete or misleading information concerning any fact or thing material to the claim commits a fraudulent insurance act, which is a crime and subjects such a person to criminal and civil penalties and may subject the participant to the suspension of his or her benefits under the Plan.

MAIL COMPLETED FORM TO: Benecard PBF PO Box 2187 Clifton, NJ 07015	QUESTIONS If you have any question, please contact Benecard PBF Member Services at: 1-888-907-0070 TDD: 1-888-802-0020 www.benecardpbf.com