

Reimbursement Claim Form

COVID-19 Over-the-Counter Test Kits



Use this form for COVID-19 over-the-counter (OTC) at-home testing kits only. Please complete a separate claim form for each family member. For all other prescription claims, please use the standard Reimbursement Claim Form: welldyne.com/member-portal

Instructions

1. Fill out all of the information on the claim form as completely as possible.
2. Complete a separate claim form for each family member.
3. Include a purchase receipt clearly showing the testing kit charges and date of purchase.
4. Mail the completed form and receipt to: **WellDyne, PO BOX 90369, LAKELAND, FL 33804**

Claims are processed within 30 business days from date received. You will be reimbursed the lesser of \$12 per test or the actual price paid. Please note, there is a maximum of 8 tests allowed per member per 30-day period.

Employee Information

Employer's Name	Group Number	
Last Name	First Name	Mid Initial
Cardholder ID#		
Address		
City	State	Zip
Daytime Phone Number	Email Address	

Patient Information

Patient's Last Name	First Name	Mid Initial	
/	/		
Birthdate (mm/dd/year)			
Male	Female		
Patient's relationship to employee:			
Self	Spouse	Child	Other

COVID-19 Test Information

Is the kit you purchased an at-home, OTC rapid result test that is visually read and results interpreted by the patient?

Yes No (Do **NOT** complete this form for a specimen collection kit that is sent a lab for processing. Use the standard claim form instead.)

Select the OTC at-home test kit(s) you purchased (select all that apply):

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|--|---|
| BinaxNOW COVID-19 Antigen Self-Test (Abbott) | QuickVue At-Home COVID-19 Test (Quidel) |
| SCoV-2 Ag Detect Rapid Self-Test (InBios) | CareStart COVID-19 Antigen Home Test (Access Bio) |
| COVID-19 At-Home Test (SD Biosensor) | Flowflex COVID-19 Antigen Home Test (ACON) |
| InteliSwab COVID-19 Rapid Test (OraSure) | BD Veritor At-Home COVID-19 Test (Becton Dickinson) |
| CLINITEST Rapid COVID-19 Antigen Self-Test (Siemens) | Ellume COVID-19 Home Test (Ellume) |
| Celltrion DiaTrust COVID-19 Ag Home Test (Celltrion) | Other (please list the product/brand) |
| iHealth COVID-19 Antigen Rapid Test (iHealth Labs) | |

Date of Purchase:	Number of Boxes:	Tests per Box:	Total Cost:
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Patient Attestation

Please check yes or no for all of the following questions related to the OTC test kit(s) you are submitting for reimbursement.

- Yes No** The test was purchased by the patient for personal use or the use of a covered plan member.
- Yes No** The test was purchased for employment purposes.
- Yes No** The test has been or will be reimbursed by another source.
- Yes No** The test has been or will be placed for resale.

I certify that the information on this claim form is correct and authorize release of all information to WellDyneRx and the Plan Sponsor. I also certify that the patient for whom this claim is made is eligible for benefits and does not have primary prescription drug coverage under any other group medical plan. I verify that the drugs listed are not for treatment of an occupational injury or disease for which the Employer has accepted liability.

This form must be signed:

Employee/Member's Signature

Date