COVID-19 OVER THE COUNTER AT HOME TESTS

Direct Member Reimbursement

CARDHOLDER INFORMATION

Cardholder ID#	RxGRP #	Plan Sponsor
	19070	TEAMSTERS LOCAL 731 HEALTH & WELFARE FUNDS

Cardholder Name   Phone

DEPENDENT INFORMATION

Complete this section only if the claim is for a spouse or dependent, not the primary cardholder.

Dependent Name

Relationship: ☐ SPOUSE ☐ CHILD ☐ OTHER

SIGNATURE / RELEASE

By signing this form, you certify that the information provided is accurate and authorize the release of all necessary information to all appropriate parties involved in the administration of this claim. All COVID-19 over the counter at home tests were received by the named individual, and he/she is eligible for benefits. None of the tests were reimbursed under another benefit plan and are for COVID-19 diagnostic purposes of the named individual.

Signature (Member, Parent or Guardian)   Print Name   Date

INSTRUCTIONS

- Write the Cardholder ID number and Group number (RxGRP) on your receipt (these can be found on your ID card).
- Enclose your itemized receipt showing the name of the COVID-19 over the counter at home test and the NDC number.
- Be sure to read the release, sign, and date this form to certify accuracy of the information provided.
- Retain copies of all documentation. Forms and receipts submitted to EmpiRx Health will not be returned.
- Maximum reimbursement is $12.00 per test.
- <u>Only FDA approved COVID-19 over the counter at home tests are subject to reimbursement.</u> A list of FDA approved COVID-19 over the counter at home tests can be found by scanning this QR Code with your smart phone camera:

> 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 anything material to the claim commits a fraudulent insurance act, which is a crime, and subjects such a person to criminal and civil penalties.

MAIL COMPLETED FORM TO:

EmpiRx Health
PO Box 1339
Mechanicsburg, PA 17055

QUESTIONS

If you have any questions, please contact EmpiRx Health Member Services at:888-309-1654
24 hours a day, 365 days a year
www.empirxhealth.com