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):

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

Date of Purchase:	**Number of Boxes:**	**Tests per Box:**	**Total Cost:**

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