IUOE Local 132 Health and Welfare Fund
P.O. Box 2626 Huntington, West Virginia 25726-2626
(304) 525-0482 or 1-800-642-3525 www.iuoe132.org

COVID-19 At-Home Over-the-Counter Test Kit Claim Form

Beginning January 15, 2022, the Health & Welfare Fund will cover the costs of at-home, over-the-counter (OTC) COVID-19 tests. The tests must be FDA-approved or FDA-authorized OTC COVID tests. The Plan will cover the full cost of the tests purchased during the public health emergency. There is no cost-sharing to the participant or any type of pre-authorization, and a prescription or doctor's order is not required.

Each individual eligible under the Plan is entitled to receive up to 8 tests per 30-day period or per calendar month. For example, a family with two parents and two children could receive 32 tests per month, free of charge. Also, there is guidance which clarifies that if there are multiple tests in a box, each test in the box counts toward the 8 per month maximum.

The tests must be purchased for the primary purpose of your individual diagnosis or treatment of COVID. The Plan does not provide coverage of OTC COVID-19 tests that are for employment reasons.

Participant Information

Name: _____ ID number or SSN: _____

Address: _____ Home Phone: _____

_____ Other Phone: _____

Name of Patient and Relation to Participant

Patient Name: _____ Patient SSN: _____

Relationship: _____

Claim Information

Provider Name: _____ Date of Service: _____

Must attach copy of receipt(s) Amount Paid: _____

Please include the original pharmacy receipt for each medication (not the register receipt). Pharmacy receipts must contain the name of the prescription, the date the prescription was filled, the name and address of the pharmacy, and the quantity purchased.

I certify that the test for which reimbursement is requested were received for use by the patient above, and that I (or the patient, if not myself) am eligible for prescription drug benefits. I also certify that the tests received were not for the treatment of an on-the-job injury.

I recognize reimbursement will be paid directly to me and assignment of these benefits to a pharmacy or any other party is void.

→ _____ → _____

Participant's Signature Date Signed