BAS A HealthComp Division

OVER-THE-COUNTER COVID TEST CLAIM FORM

This form needs to be printed and mailed to: PO Box 2920, Milwaukee, WI 53201-2920

1. Your Policy and/or Group number(s)

2. Name and address of employer

EMPLOYEE INFORMATION

3. Name of employee *(insured)* | ☐ Male ☐ Female | **Date of Birth**

4. Address of employee **Street** **City** **State** **Zip Code**

5. Employee's Medical ID or Social Security number

6. Name of Spouse or Domestic Partner | **Date of Birth** | **Social Security number**

PROVIDE INFORMATION ABOUT THE TEST KITS YOU PURCHASED

7. The test(s) were purchases for (Check only one): ____Employee ____Spouse or Domestic Partner ____Child

8. How many test kits did you purchase for this person:

Number of test kits containing a single test: _____

Number of test kits containing two tests: _____

9. Tests must be FDA-approved or authorized by the FDA under Emergency Use Authorization (EUA). You can find this information on the box of the test kit.

Enter below the manufacturer and name for each test kit:

Manufacturer: _____ Name of test:_____

Manufacturer: _____ Name of test:_____

Manufacturer: _____ Name of test:_____

Manufacturer: _____ Name of test:_____

Attach ORIGINAL receipts that reflect the date of purchase and the price for each test kit.

IF CLAIM FOR DEPENDENT, COMPLETE THIS SECTION ALSO

10. Name of your dependent | ☐ Male ☐ Female | **Date of Birth** | **Social Security Number of dependent**

IMPORTANT – PLEASE COMPLETE ATTESTATION BELOW

11. The undersigned participant certifies that the test kits purchased were NOT for employment purposes.

The undersigned participant certifies that the test kits were NOT purchased for resale.

The undersigned participant in the Medical Plan certifies that all expenses for which reimbursement is claimed by submission of this form, were purchased while the undersigned was covered under the Employer's Medical Plan and that such expenses have not been reimbursed, or are not reimbursable, by any other entity, health plan or flexible spending account. The undersigned understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which reimbursement is claimed as a proper expense under the Plan, the undersigned may be liable for the payment of all related taxes including federal, state or city income tax on amounts paid by the Plan which relate to such expense.

_____

Signed (Patient or Parent if Minor) **Date**

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