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.

Cardholder ID# Address City Daytime Phone Number COVID-19 Test Information Is the kit you purchased an at-		Mid Initial	Male	ast Name / mm/dd/year) Female elationship to er Spouse	First Nam mployee: Child	Other	Mid Initial
Cardholder ID# Address City Daytime Phone Number COVID-19 Test Information Is the kit you purchased an at-	State Email Addres	Zip	Birthdate (i Male Patient's re	mm/dd/year) Female		Other	
Cardholder ID# Address City Daytime Phone Number COVID-19 Test Information Is the kit you purchased an at-	State Email Addres	Zip	Male Patient's re	Female elationship to er		Other	
Address City Daytime Phone Number COVID-19 Test Information Is the kit you purchased an at-	Email Addres	·	Patient's re	elationship to er		Other	
City Daytime Phone Number COVID-19 Test Information Is the kit you purchased an at-	Email Addres	·		•		Other	
City Daytime Phone Number COVID-19 Test Information Is the kit you purchased an at-	Email Addres	·	Self	Spouse	Child	Other	
Daytime Phone Number COVID-19 Test Information Is the kit you purchased an at-	Email Addres	·					
COVID-19 Test Information	on	ss					
Is the kit you purchased an at-							
· ·	hama OTO "a"!-! "						
	-nome, OTO rapid r	result test that is visually	read and result	ts interpreted b	y the patient?	?	
Yes No (Do NOT com	plete this form for ϵ	a specimen collection kit	that is sent a la	b for processing	g. Use the sta	indard claim for	m instead.)
Select the OTC at-home test k	xit(s) you purchased	d (select all that apply):					
BinaxNOW COVID-19 Antig	QuickVue At-	-Home COVID-1	19 Test (Quid	el)			
SCoV-2 Ag Detect Rapid S		OVID-19 Antiger	•	,			
COVID-19 At-Home Test (S	Flowflex COVID-19 Antigen Home Test (ACON) BD Veritor At-Home COVID-19 Test (Becton Dickinson) Ellume COVID-19 Home Test (Ellume)						
InteliSwab COVID-19 Rapid							
CLINITEST Rapid COVID-1							
Celltrion DiaTrust COVID-1	Other (please list the product/brand)						
iHealth COVID-19 Antigen	Rapid Test (iHealth	n Labs)					
Date of	Number		Tests		Tota		
Purchase:	of Boxes	s:	per Box:		Cos	st:	

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	si	igne	d
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Employee/Member's Signature Date