Northern California Soft Drink Industry and Teamsters Health & Welfare Trust
4160 Dublin Blvd., Suite 400 ♦ Dublin, CA 94568
Telephone (855) 690-7250 ♦ Fax (925) 833-7301

Reimbursement Claim Form for Anthem Participants Only

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.

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: **NCSD Claims, 4160 Dublin Blvd Suite 400, Dublin, CA 94568**.

Claims are processed within 30-45 business days from date received. Please note, there is a maximum of 8 tests allowed per member per 30-day period.

Employee Information

Last Name _____ First Name _____ Mid Initial _____

Medical ID# _____

Address _____

City _____ State _____ Zip _____

Patient Information

Patient's Last Name _____ First Name _____ Mid Initial _____.

Patient's DOB (mm/dd/year) ____/____/_____.

[ ] Male [ ] Female

Patient's Relationship to employee:
[ ]Self [ ]Spouse [ ]Child [ ]Other

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)**

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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 Northern California Soft Drink Industry and Teamsters Health & Welfare Trust and HS&BA. I also certify that the patient for whom this claim is made is eligible for benefits and does not have primary coverage under any other group medical plan. I am also attesting that it was purchased for personal use, not for employment purposes, and will not be reimbursed by another source or used for resale.

Employee/Member's Signature_____**Date**_____.