Instructions for Completing UEBT Retiree Indemnity Medicare Health Plan "COVID-19 Home Test Kit – Retiree's Statement of Claim" Form (For Medicare Retirees)

Follow these steps to ensure your form is complete and your claim can be processed quickly

TO BE FILLED OUT BY RETIREE ONLY

- ☐ Read the "Important Instructions" at the top of the page
- ☐ Complete "Section One" completely. *Your Subscriber Number can be found on the front of your Medicare Crossover card issued by the TFO. Your Medicare Crossover card also has the Unique ID for your Spouse/Dependents if applicable*
- ☐ Complete "Section Two" and "Section Three" as applicable
- ☐ Complete "Section Four" to determine type of Medicare Coverage available
- ☐ Complete "Section Five" to determine the amount of reimbursement owed
- ☐ Enclose the following when mailing to the Trust Fund Office:
    - Covid-19 Test Kit – Subscriber's Statement of Claim Form for (signed and dated)
    - Copy of store receipt and UPC code from packaging
    - Attestation Form (signed and dated)
- ☐ Mail All of the above to this address:
    - UFCW Trust, PO Box 4100, Concord, CA, 94524-4100
    - Don't forget to place a stamp on the envelope

UEBT Retiree Indemnity Medicare Health Plan
COVID-19 Home Test Kit – Statement of Claim
(Medicare Retirees)

Send this claim and all related paperwork to: UFCW Trust, PO Box 4100, Concord, CA, 94524-4100
This form is to be used only for purchase price reimbursements for Over-the Counter Covid-19 at home testing kits
Duplicate claims will not only be rejected but may delay payment of the original claim

Important Instructions

- Use a separate form for:
  A. Each member of the family
- Print or type
- Fill in all items completely
- Sign your name in the space provided
- Include copy of store receipt and UPC Code from packaging
- A signed and dated Attestation Form (separate attachment)

Failure to comply with these instructions may result in your claim being delayed or returned to you

1

Subscriber name (Last, First, MI)			Subscriber number	
Mailing address	City	State	Zip	Is address new? ☐ Yes ☐ No

2

Patient's name	Patient's Unique ID	Date of birth (mo/day/yr)	Gender ☐ Male ☐ Female	Relationship to subscriber ☐ Self ☐ Spouse ☐ Child

3

Does the patient have other health coverage? ☐ Yes ☐ No	If Yes, policy ID number	Name of insuring company	Effective date
Address of insuring company			Type of Plan ☐ Group ☐ Individual
Name of policy holder	Gender ☐ Male ☐ Female	Date of birth (mo/day/yr)	Name of Employer

4

Does the patient have Medicare? ☐ Yes ☐ No	If Yes, date of birth (mo/day/yr)	Part A effective date	Part B effective date

5

Number of COVID tests purchased*: (Note: One test kit equals two tests) *Reimbursement is limited to eight tests per month	Number of test kits purchased _____ X _____ Cost of test kit(s) = $ _____ Amount of reimbursement

Subscriber's signature
I certify that the foregoing information is accurate and complete, and authorize the release of any medical information necessary to process this claim

X _____ Date _____

Mail: P.O. Box 4100 · Concord, CA 94524-4100
Telephone: (800) 552-2400 · Facsimile: (925) 746-7549
www.ufcwtrust.com

UFCW & Employers Benefit Trust (UEBT)

OTC COVID-19 Testing Kit Attestation Statement

Effective for FDA-Approved OTC COVID-19 Test Kits purchased on January 15, 2022, through the end of the COVID-19 Public Health Emergency

I _____[print full name of participant], hereby attest that the over-the-counter (OTC) COVID-19 rapid home testing kit(s) I purchased on _____[enter date] for either myself and/or my dependent(s) who are currently enrolled in the UFCW & Employers Benefit Trust were purchased for personal diagnostic testing use only. The testing kit(s) contained [1 or 2] individual tests. In addition, I hereby attest the testing kit(s):

(1) were not purchased as a condition of employment or for employment purposes;

(2) have not been, and will not be, financially reimbursed by another source;

(3) will not be used by any individual who is not a family member who is enrolled in the Plan; and

(4) will not be re-sold to a third-party.

I do hereby attest that this information is true, accurate and complete to the best of my knowledge, and I understand that if any of statements above are incorrect or false, I will be required to repay the Plan any amount I received for reimbursement of such testing kit(s).

Attached to this document is my receipt showing proof of purchase. Documentation must include the UPC code for the test and a receipt from the seller of the test documenting the date of purchase and price.

_____

Signature of Plan Participant

_____

Printed Name of Plan Participant

_____

Date Signed