HAWAII LABORERS HEALTH AND WELFARE FUND

1440 Kapiolani Blvd Ste 800 Honolulu, HI 96814– Fax (808) 441-8750
PHONE (808) 441-8600-NEIGHBOR ISLANDS DIAL DIRECT 1 (888) 520-8078

COVID-19 OVER-THE-COUNTER (OTC) TEST KIT CLAIM FORM

SELF -FUNDED PLAN PARTICIPANTS ONLY

Use for COVID-19 over-the-counter (OTC) testing kits only. Please complete one form per patient.

Please refer to the back of this form for benefit information.

PART I: SUBSCRIBER INFORMATION

LAST NAME	FIRST NAME	M.I.	GENDER	DATE OF BIRTH
			☐ M ☐ F	MM DD YYYY

MAILING ADDRESS (NO., STREET)	CITY	STATE	ZIP CODE

IS THIS A CHANGE OF ADDRESS?	MEMBER ID OR LAST FOUR OF SOCIAL SECURITY NUMBER	TELEPHONE NUMBER:
☐ Yes ☐ No		

PART II: PATIENT INFORMATION: *Complete this section only if the patient is not the SUBSCRIBER*

PATIENT'S NAME (LAST NAME)	(FIRST NAME)	(M.I.)	RELATIONSHIP TO SUBSCRIBER	DATE OF BIRTH	GENDER
			☐ Spouse ☐ Child ☐ Other	MM DD YYYY	☐ M ☐ F

OTHER COVERAGE INFORMATION: *Complete only if claim is for a spouse/dependent and/or other coverage is in effect*

IS THE PATIENT COVERED UNDER ANOTHER HEALTH INSURANCE PLAN?	☐ Yes ☐ No

If yes, please provide: NAME OF HEALTH INSURANCE COMPANY	EFFECTIVE DATE OF COVERAGE MM DD YYYY	POLICY NUMBER	TYPE OF PLAN (HMO or PPO) IF KNOWN

IS THE PATIENT COVERED UNDER MEDICARE?	☐ Yes ☐ No

If you answered Yes, and the other insurance company is primary, you must submit a claim to your primary insurer first. After your primary insurance processed your claim. please send us this form and (a) a copy of the explanation of benefits (EOB) and (b) the itemized bill(s) for this claim.

PART III: DESCRIBE THE TEST KIT(S) *Please answer the following questions about the test(s) for which you are seeking reimbursement.*

Please select the response that best describes the type of test for which you are seeking reimbursement.

☐ An at-home, over-the-counter (OTC) rapid result test, visually read and results interpreted by the customer.

☐ An at-home, specimen collection kit where the specimen is sent to a lab or other facility for processing and interpretation of results. (**STOP:** This form should not be used to request reimbursement for specimen collection kits processed by a lab or other facility.)

Please select the product/brand. (select all that apply)

Please select the OTC at-home test kit you purchased:

☐ BinaxNOW COVID-19 Antigen Self-Test (Abbott)
☐ COVID-19 At-Home Test (SD Biosensor)
☐ CLINITEST Rapid COVID-19 Antigen Self-Test (Siemens)
☐ iHealth COVID-19 Antigen Rapid Test (iHealth Labs)
☐ CareStart COVID-19 Antigen Home Test (Access Bio)
☐ BD Veritor At-Home COVID-19 Test (Becton Dickinson)
☐ SCoV-2 Ag Detect Rapid Self-Test (InBios)
☐ InteliSwab COVID-19 Rapid Test (OraSure)
☐ Celltrion DiaTrust COVID-19 Ag Home-Test (Celltrion)
☐ QuickVue At-Home OTC COVID-19 Test (Quidel)
☐ Flowflex COVID-19 Antigen Home Test (ACON)
☐ Other: _____

Date of Purchase: MM DD YYYY	Number of Boxes:	Tests per Box:	Total Cost: $

PART IV: CUSTOMER ATTESTATION

Please check yes or no for **all** of the following questions.

Yes	No	*The over-the-counter test kit submitted for reimbursement on this form:*
☐	☐	Was purchased by the customer for personal use or the use of a covered plan member
☐	☐	Was purchased for employment purposes
☐	☐	Was purchased for travel, attendance at sporting event, or social purposes
☐	☐	Has been (or will be) reimbursed by another source
☐	☐	Has been (or will be) placed for resale

PART V: REQUIRED DOCUMENTATION

When submitting your OTC test-kit claim, please include the required documentation with your form. Incomplete submissions may not be considered for reimbursement.

- Purchase Receipt clearly showing the date of purchase and testing kit charges.

CERTIFICATION

Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act which is a crime.

I certify that the information supplied is true and correct.

SUBSCRIBER'S SIGNATURE	DATE: MM	DD	YYYY
X			

1. Mail this claim form(s) and required documentation to:

Claims Department
1440 Kapiolani Blvd., Ste. 800
Honolulu, HI 96814

2. Fax this claim forms and required documentation to: **808-441-8750**

COVID-19 OVER-THE-COUNTER (OTC) TEST KIT

You are eligible for four (4) FREE at home COVID-19 tests per household from the federal government by visiting www.covidtests.gov. These tests are free of charge and they do not count toward the 8 test per month maximum described below.

Self-Funded Comprehensive Medical Plan - Benefit Information

Over the Counter Test Coverage for COVID-19

On January 10, 2022, the Departments of Labor, Health and Human Services (HHS), and the Treasury (the Departments) issued FAQs pertaining to the coverage of COVID-19 self-administered or at-home tests (Over-the-Counter COVID-19 tests) without an order or individualized clinical assessment by an attending healthcare provider.

Pursuant to these rules, the Fund will reimburse participants for:

1. The cost of up to 8 over the counter COVID-19 tests per calendar month. Sales tax and shipping charges are not eligible for reimbursement.
2. To be eligible for reimbursement, tests must be purchased on or after January 15, 2022, and coverage will continue until the end of the national health emergency.
3. For any applicable test purchases, you will be responsible for the cost of the test at the time of purchase and submit a claim form for reimbursement with Pacific Administrators, Inc. (PAI).
4. Only tests that are self-administered and self-read at home and that are FDA approved are eligible for reimbursement. Please check with PAI for a list of FDA approved tests that are eligible for reimbursement or go to the FDA website for a list of approved tests: https://www.fda.gov/medical-devices/coronavirus-disease-2019-covid-19-emergency-use-authorizations-medical-devices/in-vitro-diagnostics-euas-antigen-diagnostic-tests-sars-cov-2
5. A specimen collection kit where the specimen is sent to a lab or other facility is not covered under this benefit.
6. Tests are only eligible for reimbursement if they are used for diagnostic purposes. Tests purchased for employment purposes, travel purposes, or social use are not eligible for reimbursement. When completing a claim form for reimbursement you will need to attest that the purchased tests are for your personal use for diagnostic purposes, but you are not required to get a physician order for the tests.

COMPLETING A CLAIM FORM

PART I: SUBSCRIBER INFORMATION – This section **MUST** be completed.

PART II: PATIENT INFORMATION (only complete this section if the Patient is not the Subscriber)
OTHER INSURANCE INFORMATION – **IMPORTANT:** If the patient has other insurance as their primary insurer, they must submit a claim form to their primary insurance.

PART III: DESCRIBE THE TESTS: This section **MUST** be completed.

PART IV: CUSTOMER ATTESTATION: This section **MUST** be completed

PART V: REQUIRED DOCUMENTATION: **Receipt (original or copy) from the purchase, clearly showing the date of purchase and testing kit charges.**

CERTIFICATION: SUBSCRIBER SIGNATURE REQUIRED

SUBMIT CLAIM: To the address or fax number on the form.

In addition, if you are feeling ill or believe you may have COVID-19, you may continue to see a physician as before and the physician may order a test that is conducted by a lab. Such tests ordered by a physician continue to be covered at no cost to you until the end of the national health emergency.

Kaiser Participants and HMSA Akamai Advantage Participants: Please contact Kaiser or HMSA directly for more information on eligible tests for coverage, how to obtain them, and how to file for reimbursement.