CARRIER USE ONLY

APWU HEALTH PLAN

P.O. BOX 1358 GLEN BURNIE, MD 21060

PHONE: 800-222-APWU

OTC RAPID COVID19 TEST CLAIM FORM

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. INSURED'S ID NUMBER

2. INSURED'S NAME & ADDRESS

(IF ADDRESS INCORRECT, PLEASE CORRECT ABOVE)

3. PATIENT (CHECK PATIENT'S NAME: ONLY ONE PATIENT PER CLAIM FORM)

4. PATIENT'S BIRTH DATE / /

5. PATIENT'S SEX CIRCLE: MALE FEMALE

6. PATIENT'S **APWU GROUP NUMBER** AS INDICATED ON YOUR PRESCRIPTION DRUG CARD (IF NOT INCLUDED ABOVE)

7. DOES PATIENT HAVE MEDICARE? IF YES, PLEASE INDICATE EFFECTIVE DATE AND ATTACH EOMB FROM MEDICARE CARRIER.

❑ PART "A" EFFECTIVE DATE _____ ❑ PART "B" EFFECTIVE DATE _____

8. IS PATIENT COVERED UNDER ANY OTHER HEALTH INSURANCE? YES ❑ NO ❑

IF YES, PLEASE INDICATE NAME OF POLICY HOLDER. PLAN NAME, ADDRESS, POLICY NO. AND PHONE NO. IF NO, PLEASE SIGN AND DATE.

IF YES, PLEASE ATTACH PAYMENT STATEMENT FROM OTHER CARRIER.

10. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE AUTHORIZING THE RELEASE OF ALL MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

SIGNED: _____ DATE: _____

CLAIMS FILING INSTRUCTIONS: Please Print

The patient or HIPAA representative must complete and sign this form.

You must attach supporting receipts. Cancelled checks and balance due statements are not acceptable. Please list purchases in date order.

1. Claims must be submitted by December 31 of the year after the year you incur the expense. Failure to file within this limit will invalidate your claim.

**More information regarding coverage and a list of covered OTC Covid19 Rapid tests can be located at https://www.apwuhp.com.

Date of Purchase	Brand of OTC Covid19 Rapid Test	Number of Boxes Purchased	Number of Tests included per box	Pharmacy/Retailer Purchased from Name and Address	Charge

I certify the list of items above were purchased for the patient named and **DO NOT** include purchases that pertain to other patients.

WARNING: Any intentional false statement on this claim or willful misrepresentation relative thereto is a violation of the law, etc. (18 U.S.C. 1001).

By signing below, I certify that the kit(s) for which reimbursement is requested are not related to employment mandates and is correct as it pertains to me.

Date _____ Member's Signature _____