COVID-19 TEST KIT REIMBURSEMENT REQUEST FORM

Use this form to request reimbursement for FDA-authorized COVID-19 test kits purchased on or after January 15, 2022 at a retail store, pharmacy or online retailer.

Please print clearly.

1) Member information

Member ID (TSJ): _____

Last name: _____ First name: _____

Mailing street address: _____ Apt#: _____

City: _____ State: _____ Zip: _____

2) Enter the full name of the Spouse/Dependents & the # of tests per partcipant

Member _____#_____ Spouse _____#_____

Child #1 _____ #_____ Child #2_____#_____

Child #3 _____#_____ Child #4_____ #_____

Child #5 _____#_____ Child #6_____ #_____

3) Purchase information

Name of Pharmacy, store or online retailer _____

Date of Purchase _____ Product name (s)_____
(receipt of purchase must be submitted with this form)

4) Amount of reimbursement

Total # of tests _____ X $12.00 per test = _____
(example: if test kit contains 2 tests, count as 2 tests; limit is 8 tests per participant)

5) Acknowledgement

I certify that the OTC COVID-19 test kits for which reimbursement is requested were received for use by the patient/patients listed above. I also certify that the test kits received were not for employment-related COVID-19 testing requirements.

Member Signature _____ Date _____

Mail the completed form and receipts to:
Tri-State Joint Fund
609 West Johnson Avenue 2nd Floor
Cheshire, CT 06410