How to get reimbursed for over-the-counter COVID-19 test kit purchases

PHBP participants are eligible to receive reimbursement for over-the-counter COVID-19 test kits. To request reimbursement, **simply submit the following form** within one year of purchase along with your receipt or proof of payment and UPC (the barcode on the outside of the box).

Requirements for reimbursement:

- Test kits must have been purchased on or after January 15, 2022.
- Reimbursement is limited to 8 test kits per covered family member per month.
- Tests must be FDA authorized home test kits. **Check this complete list of authorized tests**.
- Test kits may be purchased online, at the pharmacy, or other retail location.

MAGNACARE℠

PLEASE READ INSTRUCTIONS ON REVERSE SIDE BEFORE COMPLETING APPLICATION

Pension, Hospitalization and Benefit Plan

HOSPITALIZATION, SURGICAL AND MEDICAL BENEFITS OF THE JOINT INDUSTRY BOARD OF THE ELECTRICAL INDUSTRY

158-11 Harry Van Arsdale Jr. Avenue ● Flushing, New York 11365-3095 ● 1-718-591-2000

TO BE COMPLETED BY PARTICIPANT

1. Participant's Name _____ 2. Participant's PID #_____

3. Participant's Address_____ 4. Home Phone #_____
(Area Code)

_____

5. Current Employer _____ 6. Date of Marriage_ _____

7. Patient's Name_____ 8. Patient's Date of Birth_____

9. Patient Relationship ☐ Self ☐ Spouse ☐ Child 10. Full-Time Student? ☐ Yes ☐ No

11. Other Health Insurance? ☐ Yes ☐ No 12. Type of Plan ☐ Group ☐ Individual

13. If yes, enter insurance company, plan name, policy holder, policy number and effective date of coverage _____

_____

14. Is claim related to: A) Patient's Employment ☐ Yes ☐ No

B) An Accident ☐ Yes ☐ No If yes, give date and description of accident_____

_____

15. Is the participant paying for or receiving continuation coverage (COBRA) under this Plan? ☐ Yes ☐ No

16. Is this patient under a Qualified Medical Child Support Order? ☐ Yes ☐ No

17. Is the patient covered by Medicare? ☐ Yes ☐ No
If yes, indicate effective date of coverage. Part A_____ Part B_____

DATE OF SERVICE	PROVIDER'S NAME	SERVICES RENDERED	CHARGE

Any intentional statement of incomplete, inaccurate and/or incorrect information may result in disciplinary action including the institution of a civil and/or criminal proceeding.

I have read the foregoing Notice and I certify to the completeness and accuracy of this application. I further certify that I have not submitted these bills for payment through the Pension, Hospitalization and Benefit Plan prior to this date.

_____

Participant's Signature Patient's Signature Date

PLEASE NOTE: APPLICATION CANNOT SERVE AS A BILL

(Over)

INSTRUCTIONS

1. Fill in all information on application and sign where indicated. If you are a participant who is paying for or receiving continuation coverage (COBRA) under this Plan, indicate your name and your social security number in items 1 and 2 and omit item 5.

2. Attach your bill(s) to this form and mail to **MagnaCare** at the address below.

   A. A separate claim form must be completed for each patient.

   B. All bills must be itemized, include the provider's Tax ID number, diagnosis code(s) and procedure code(s).

   C. When **Medicare** is the primary insurance, paper claims are required for the following services:

   - Covered services rendered by the Veteran's Administration;
   - The shingles (Zostavax) vaccination;
   - Hearing aid devices;
   - Diabetic needles and syringes;
   - Foreign travel claims; and
   - All coordination of benefit claims.

MAGNACARE INC. – JIB (LOCAL 3)
P.O. BOX 1001
Garden City, NY 11530
1-877-624-6210
www.magnacare.com

Claims covered by Medicare for dates of service prior to August 1, 2011:

Applications must be mailed to the Pension, Hospitalization and Benefit Plan and submitted with **all pages** of the explanation of benefit payment voucher from Medicare. It is not necessary to submit copies of the corresponding bills.

The recipient of benefits under this Plan, by applying for, and in fact accepting such benefits, agrees to reimburse the Plan for all such benefits received, from the proceeds of any claim, settlement, judgment or other recovery from a third party, or his insurer, whose conduct caused the injuries which were the basis for the claim for benefits under this Plan.

All claims must be filed within one year following the date of service. Any claim that is not submitted within a 12-month period will be denied as untimely.

(Over)