LAUNDRY & DRY CLEANING WORKERS LOCAL NO. 52 HEALTH AND WELFARE TRUST

1200 Wilshire Blvd., Fifth Floor, Los Angeles, CA 90017-1906 Phone: (562) 463-5060

OVER THE COUNTER COVID-19 CLAIM FORM

Please answer all applicable questions. Return this completed form with itemized receipt(s) for each claim to the above address. Failure to complete this form in full may delay payment of your claim.

EMPLOYEE DATA

Name (First, Middle & Last)	Sex F ☐ M ☐	Date of Birth	Social Security #

Home Address	City	State	Zip	Home Phone

Employed By	

PATIENT DATA

Name (First, Middle & Last)	Sex F ☐ M ☐	Date of Birth	Social Security #

CHILD DATA (must be completed if claim is for child)

Name (First, Middle & Last)	Sex F ☐ M ☐	Date of Birth	Social Security #

Home Address (if different from address shown above)

OTHER INSURANCE DATA

Was the Patient covered by any other Group Insurance, Medicare or other governmental plan at the time these charges were incurred?

Yes ☐ No ☐

Give the name and address of any other insurance company or organization providing benefits to you or your dependent children.

Insured Name	Name and Address of Insurance Company or Organization providing benefits	Policy #

PHARMACY INFORMATION

Name of Pharmacy

Street Address	City	State	Zip	Telephone

OTC COVID-19 TEST KIT INFORMATION

COVID-19 Test Kit Name

Number of Kits	Purchase Price	Purchase Date

I/We jointly certify that the COVID-19 test kit was purchased by me (member) for personal use or the use of a covered plan member and was not purchased for employment services. I/We further certify that this test will not be reimbursed by another source nor placed for resale.

_____ _____ _____ _____

Employee Signature **Date** **Spouse (Patient) Signature** **Date**

I/We jointly certify that the above information is true and correct. I/We hereby authorize all providers of medical care to furnish the Laundry & Dry Cleaning Workers Local No. 52 Health and Welfare Trust Fund with full information regarding this claim including copies of their records. I/We further authorize the release of this information to any third party, if the release of the information is necessary to the review or payment of the claim; i.e. for a medical necessity review, coordination of benefits determination, etc.

_____ _____ _____ _____

Employee Signature **Date** **Spouse (Patient) Signature** **Date**

AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I hereby authorize payments directly to the provider of service for all benefits, if any, otherwise payable to me for services on the attached claim but not to exceed the reasonable and customary charge for those services.

_____ _____

Signed (Insured Person) **Date**