

# Simplified Benefits Administrators COVID-19 At-Home Over-The-Counter Testing Reimbursement Form



**PLEASE ATTACH ITEMIZED RECEIPTS**

Employee Information:			
Last Name:	First Name:	M.I.:	Date of Birth: (MM/DD/YY)
Enrollee Number:	Group Number:	Gender:	Marital Status:
Street Address:		City:	State:      Zip Code:
Employer Name:			
Dependent Information: if applicable			
Last Name:	First Name:	M.I.:	Date of Birth: (MM/DD/YY)
Gender:	Relationship:		
COVID-19 At-Home Over-The-Counter Test Information:			
Number of Tests Purchased:		Purchase Date:	
Please indicate which member the tests were purchased for:		Purchase Location:	

I certify that the test purchased was authorized by the U.S. Food and Drug Administration and was used for personal use only. I understand employment related testing is not eligible for reimbursement.

\_\_\_\_\_  
Signature of employee

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of employee

\_\_\_\_\_  
Relationship to dependent, if applicable

**Questions? Call Simplified Benefits Administrators at 1.800.207.1018**

**Please submit this form and all attachments to Simplified Benefits Administrators within 10 days of purchase using one of the following options.**

**E-Mail**

[customerservice@simplifiedbenefitsadministrators.org](mailto:customerservice@simplifiedbenefitsadministrators.org)

**Fax**

801.442.0041

10375 Park Meadows Drive Suite 125, Lone Tree, CO 80124  
1.800.207.1018  
Simplifiedbenefitsadministrators.org