

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

Fax

801.442.0041

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