

## FORM FOR SUBMISSION OF REIMBURSEMENT CLAIMS

Employer Name			Employer FEIN					
Employer Street Address			City State Zip Code					
					Olate			
Employee Name		Social Security	Number	Employee Number		Date o	of Hire	
Employee Street Address		C	City		State		Zip Code	
Type of COVID-19 Test for Which Reimbursement is Requested			Name of the Manufacturer of the Test and US Food & Drug Administration Emergency Use Authorization Number of the Test					
Is the cost of COVID-19 testing covere	d by the employee's health ben	efit plan? (Yes or	No)					
Is this a claim for reimbursement of co	st of COVID-19 testing? (Yes or	r No)						
Is the employer or the employee the C This form must be properly completed, and s signing this form, you certify under penalty of	igned by both the employer and emp perjury, based on information and b	Important – Read E	Before Signing	the cost of testing not o	covered by the emp	bloyee's h	ealth benefit plan. By I the attached	
documents are true, accurate, and complete.			<b>T</b> :41 -		Data			
Employer Signature	Employer Printed Name		Title		Date			
Employee Signature	Employee Printed Name		Title		Date			
For Reimbursement Claims: In addition to 1 documents evidencing that each test was col and Drug Administration (FDA) emergency u legible format. FDA emergency use authoriza authorizations-medical-devices/in-vitro-diagn Mail the completed form(s) and all docum Failure to furnish the properly completed form Please see the instructions for completing	nducted, the name of each employee se authorization number for each tes ation number information for COVID- ostics-euas ents to: Department of Finance and n(s) or the required documentation w	e tested, the name of it, and a paycheck st 19 tests can be foun Administration, Offic	the manufacturer of the ub for the most recent p d at: https://www.fda.go e of Accounting, P O B	e COVID-19 test, the c pay period for each em w/medical-devices/cord	ost of COVID-19 te ployee tested with onavirus-disease-2	esting, the all docum	United States Food ents submitted in	

## IMPORTANT PLEASE READ

## EMPLOYERS THAT SEEK TO RECEIVE SFRF FUNDS

IMPORTANT: Prior to receiving State Fiscal Recovery Funds, an employer must execute the Arkansas Department of Finance and Administration COVID-19 Testing Program Subrecipient Agreement and agree to abide by its terms and conditions.

## **INSTRUCTIONS FOR COMPLETING THIS FORM:**

- 1. Employer name provide the complete legal name of the employer.
- 2. Employer FEIN provide the employer's Federal Employer Identification Number.
- 3. Employer Street Address provide the physical street address of the employer.
- 4. **City** provide the city in which the employer is located.
- 5. State provide the state in which the employer is located.
- 6. **Zip Code** provide the employer's zip code.
- 7. **Employee Name** provide the full name of the employee.
- 8. Social Security Number provide the social security number of the employee.
- 9. Employee Number provide the employee's employee number.
- 10. Date of Hire provide the date of hire of the employee.
- 11. Employee Street Address provide the physical street address of the residence of the employee.
- 12. **City** provide the city in which the employee resides.
- 13. **State** provide the state in which the employee resides.
- 14. Zip Code provide the employee's zip code.
- 15. Type of Test for Which Reimbursement is Requested provide whether the test for which you are requesting reimbursement is an antigen detection, molecular diagnostic, or proof of immunity test.
- 16. Name of Test Manufacturer and US FDA EUA Number provide the name of the manufacturer of the COVID-19 test and provide the United States Food and Drug Administration.
- Emergency Use Authorization number for the COVID-19 test.
- 17. Is the cost of COVID-19 testing covered by the employee's health benefit plan? provide a yes or no answer to this question.
- 18. Is this a request for prearranged COVID-19 testing? provide a yes or no answer to this question.
- 19. Is this a claim for reimbursement of cost of COVID-19 testing? provide a yes or no answer to this question.
- 20. Is the employer or the employee the Claimant for reimbursement? provide whether the employer or employee is the Claimant for reimbursement; answer by stating employer or employee.
- 21. Employer Signature a person authorized by the employer to bind the employer must sign in this box.
- 22. Employer Printed Name print the name of the authorized person that is signing on behalf of the employer.
- 23. Title provide the title of the person signing on behalf of the employer.
- 24. Date provide the date that the authorized person signed on behalf of the employer.
- 25. Employee Signature the employee must sign in this box.
- 26. Employee Printed Name provide the employee's printed name in this box.
- 27. Title provide the employee's title in this box.
- 28. Date provide the date that the employee signed this form.