FORM FOR SUBMISSION OF REIMBURSEMENT CLAIMS

Employer Name	Employer FEIN		
Employer Street Address	City	State	Zip Code
Employee Name	Social Security Number	Employee Number	Date of Hire
Employee Street Address	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 covered by the employee's health benefit plan? (Yes or No) _____

Is this a claim for reimbursement of cost of COVID-19 testing? (Yes or No) _____

Is the employer or the employee the Claimant for reimbursement? (Employer or Employee) _____

Important – Read Before Signing

This form must be properly completed, and signed by both the employer and employee, when requesting reimbursement for the cost of testing not covered by the employee's health benefit plan. By signing this form, you certify under penalty of perjury, based on information and belief formed after reasonable inquiry, the statements and information contained in this form and the attached documents are true, accurate, and complete.

Employer Signature	Employer Printed Name	Title	Date
Employee Signature	Employee Printed Name	Title	Date

For Reimbursement Claims: In addition to the properly completed form(s), the following documents **must** be attached: the original, or a digitally scanned copy, of the invoice, receipt, or other documents evidencing that each test was conducted, the name of each employee tested, the name of the manufacturer of the COVID-19 test, the cost of COVID-19 testing, the United States Food and Drug Administration (FDA) emergency use authorization number for each test, and a paycheck stub for the most recent pay period for each employee tested with all documents submitted in legible format. FDA emergency use authorization number information for COVID-19 tests can be found at: https://www.fda.gov/medical-devices/coronavirus-disease-2019-covid-19-emergency-use-authorizations-medical-devices/in-vitro-diagnostics-euas

Mail the completed form(s) and all documents to: Department of Finance and Administration, Office of Accounting, P O Box 3278, Little Rock, AR 72203-3278
Failure to furnish the properly completed form(s) or the required documentation will delay your claim for reimbursement.

Please see the instructions for completing the form on the next page.

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.