OPTUMRx®

COVID 19 TEST KIT REIMBURSEMENT REQUEST FORM

Use this form to request reimbursement for FDA-authorized COVID-19 test kits purchased on or after January 15, 2022 at a retail store, pharmacy or online retailer. Reimbursement requests are processed in about 4-6 weeks.

Complete one form per member. Please print clearly.

1 Member information

RxGroup *(see ID card)*	Member ID *(see ID card)*	
Last name	First name	MI
Mailing street address		Apt. #
City	State	ZIP
Test Kit(s) is for ○ Self ○ Spouse ○ Dependent	Date of Birth *(mm/dd/yyyy)*	

2 Custodial parent information

For reimbursement requests from a parent for a child (under the age of 18) when the requesting parent meets both of the following requirements:

1. Parent is not enrolled in the same Group Health plan as the child
2. Parent does not reside in the same household as the subscriber under the child's Group Health plan

If your child is covered under two or more health plans, state law determines the order of benefits for processing claims.

Legal custodian's name	Legal custodian's contact phone
Custodian requesting reimbursement name	Custodian requesting reimbursement contact phone
Address payment is to be mailed to	

3 Purchase information

Name of pharmacy, store or online retailer	Pharmacy/Retailer address
Date of purchase	Product name
Number of tests requesting reimbursement	Total cost of purchase (including tax)

4 Reason for request

☐ Reimbursement for FDA-authorized COVID 19 test kit

5 Acknowledgement

I certify that the OTC COVID-19 test kits for which reimbursement is requested were received for use by the patient above, and that I (or the patient, if not myself) am eligible for benefits. I also certify that the test kits received were not for employment-related COVID-19 testing requirements.

Signature: _____ **Date:** _____

Instructions for submitting form

1. Covered member can submit a monthly claim form for up to (8) COVID 19 test kits.
2. Include the original receipt for each COVID-19 test kit
3. Read the Acknowledgement (section 5) on the front of this form carefully. Then sign and date. Print page 2 of this form on the back of page 1.
4. Send completed form with pharmacy receipt(s) to: **OptumRx Claims Department, PO Box 650334, Dallas, TX 75265-0334**

Note: Incomplete forms may be returned and delay reimbursement. Reimbursement is not guaranteed. Claims are subject to your plan's limits, exclusions and provisions.

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties, including fines and/or imprisonment, or denial of benefits.*

***Arizona:** For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment or a loss is subject to criminal and civil penalties.

***California:** For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

The company does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities.

Free services are provided to help you communicate with us, such as letters in other languages or large print. You may also ask to speak with an interpreter. To ask for help, please call the toll-free phone number listed on your ID card.

ATENCIÓN: Si habla **español (Spanish)**, La compañía no discrimina por raza, color, nacionalidad, sexo, edad o discapacidad en actividades y programas de salud.

Se brindan servicios gratuitos para ayudarle a comunicarse con nosotros, como cartas en otros idiomas o en letra grande. También puede solicitar comunicarse con un intérprete. Para solicitar ayuda, llame al número de teléfono gratuito que figura en su tarjeta de identificación.

請注意：如果您說中文 (Chinese)，公司不会基于种族、肤色、国籍、性别、年龄或残疾而在健康计划和活动中歧视任何人。

为帮助您与我们沟通，我们提供一些免费服务，例如用其他语言书写的信件或大字体。您也可以要求与口译员对话。欲寻求帮助，请拨打您的 ID 卡上列出的免费电话号码。