caremark®

C vid-19 Test Kit Reimbursement Claim F rm

Im ortant!

- Alwa s all w u t 30 da s fr m the time u receive the res onse t all w f r claims cessing and deliver .
- Kee a c f all d cuments submitted f r ur rec rds.
- D n t sta le recei ts r attachments t this f rm.
- Reimbursement is n t guaranteed and ther c ntract r will review the claims subject t limitati ns, e clusi ns and visi ns f the an.

STEP 1 Card H lder/Patient Inf rmati n

This section must be fully completed to ensure proper reimbursement of your claim.

Card H lder Inf rmati n

Identi cati n Number (refer t ur ID card)

Gr u Number/Gr u Name

Last Name

First Name

MI

Address

Address 2

Cit

State

Zi P stal C de

C untr

Patient Inf rmati n–Use a se rate claim f rm f r each tient

Last Name

First Name

MI

Date f Birth

Ph ne Number

Relati nshi Primar Member

Member

○ ○ ○ ○

Im ortant! A signature is REQUIRED

NOTICE

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 nes, denial of bene ts and/or imprisonment.

OTC test(s) were purchased for personal use, not employment, has not been reimbursed by another source, and is not for resale.

I certify that I (or my eligible dependent) have received the medicine described herein. I certify that I have read and understood this form, and that all the information entered on this form is true and correct.

K

Signature f Patient (REQUIRED) **Date**

STEP 2 Submissi n Re irements

Y u MUST include all riginal harmac r cash register recei ts r n-line o f f urchase in rder f r ur claim t o cess. The minimum inf rmati n that must be included n ur harmac r cash register recei ts r n-line o f f urchase is listed bel w:

- Date of Purchase
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