



*A Division of A&A Services, LLC*  
224 North Park Ave. Fremont, NE 68025  
Phone: (800) 228-3108 • Fax: (888) 810-1394

## OVER-THE-COUNTER (OTC) COVID-19 TEST KIT CLAIM REIMBURSEMENT REQUEST

### These items will be required for reimbursement:

1. Proof of purchase (e.g. an original receipt from the pharmacy or a photo of the receipt), including the purchase price and date of purchase
2. This form filled out and signed

### To submit, please send this form to one of the two options:

1. **Email:** covidtest@savrx.com
2. **Mail:**  
ATTN: COVID-19 Test  
Sav-Rx  
224 N. Park Ave  
Fremont, NE 68025

### PATIENT INFORMATION

Cardholder Name: \_\_\_\_\_

Card ID: \_\_\_\_\_

Group: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Number of OTC COVID-19 Tests: \_\_\_\_\_

Name of OTC COVID-19 Test(s): \_\_\_\_\_

UPC or NDC (typically by the barcode on tests): \_\_\_\_\_

Date of Purchase: \_\_\_\_\_

### ATTESTATION

I, the undersigned, \_\_\_\_\_ certify under penalty of law 1) that all information provided on this form is truthful and accurate, 2) that I purchased the OTC COVID-19 test(s) included in this reimbursement request for my own personal use (or for the use of my eligible dependent under my health plan) and *not* for employment purposes, 3) that the OTC COVID-19 test(s) have not been (and will not be) reimbursed by another source; and 4) that the OTC COVID-19 test(s) will not be resold. I understand that, if any material fact herein is false, I will be required to repay in full any amounts reimbursed to me by the Plan.

Signature \_\_\_\_\_ Date \_\_\_\_\_