OTC COVID-19 At-Home Test Claim Form

Direct Member Reimbursement

This claim form must be completed to request reimbursement of OTC COVID-19 at-home test(s).

Section 1: Member Information

1. ALL information below MUST be completed and submitted with original receipt(s) and NDC or UPC from OTC COVID-19 at home test package(s). See example – Section 3
2. A separate claim form for each member MUST be submitted.
3. Member ID Number and Group Number on form must exactly match what is printed on the member ID card.
4. Please allow 6 to 10 weeks for processing and payment of submitted claim(s). Claim forms submitted without all required information will be declined and returned for resubmission.

Member Last Name	Member First Name	Member MI
Telephone Number	Date of Birth	Relationship
		Self Child/Dependent Spouse Other
Member ID Number	Group Number	Email Address
Mailing Address		
City	State	ZIP Code
Member Signature		Date Signed

I certify that the medication(s) and/or product(s) 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 prescription drug benefits. I also certify that the medication(s) and/or product(s) received were not for treatment of an on-the-job injury. I recognize reimbursement will be paid directly to me and assignment of these benefits to a pharmacy or any other party is void.

Name: ,
DOB:

Section 2: OTC COVID-19 At-Home Test Purchase Information

1. ALL information below MUST be completed.
2. A separate claim form for each distributor (pharmacy/online/retailer) MUST be submitted.

Distributor: Pharmacy/Online/Retailer Name		Telephone Number*
Street Address*		
City*	State*	ZIP Code*

***If Available**

Section 3: Receipt Information

1. ALL information below MUST be completed.
2. Original receipt(s) or printout(s) MUST be included and taped in the section below. Please DO NOT staple.
3. If receipt(s) are missing any of the information outlined in the section below, please ensure it is included on the form.
4. Original receipts will not be returned, we recommend making a copy of the completed claim form and receipt(s) for your records.

NDC and/or UPC (examples below)	Product Name
	BinaxNOW COVID-19 Ag Home Test Kit COVID-19 OTC Antigen Kit Ellume COVID-19 Home Test Kit Flowflex COVID-19 Ag Home Test Kit InteliSwab COVID-19 Rapid Test Kit On/Go COVID-19 Antigen Test Kit QuickVue At-Home COVID-19 Test Kit Other:
Date of Purchase	Number of COVID-19 Test(s) in package
Price per Package	Total Purchase Price

Name:
DOB: ,

OTC COVID-19 at-home tests will have either a NDC and/or UPC located on the package. See examples:

NDC

12345-0123-12

UPC

Attach the following:

1. Original Distributor Receipt
2. Original NDC and/or UPC from packaging – DO NOT STAPLE

Attach Distributor Receipt Pharmacy/Online/Retailer Name	Attach NDC and/or UPC From Original Packaging

Attach additional pages if needed.

Submit form along with required documents to:
Script Care, LTD
ATTN: Accounting Department
6380 Folsom Drive
Beaumont, Texas 77706
accounting@scriptcare.com
Fax: (409) 924-7819