



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 take up to 4-6 weeks to process.

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 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 applicable tax & shipping)

3 Reason for request

Reimbursement for FDA-authorized COVID 19 test kit

4 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 or as defined by your State benefit.
2. Include the original receipt for each COVID-19 test kit
3. Read the Acknowledgement (section 4) 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.



UnitedHealthcare Community Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. In other words, UnitedHealthcare Community Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan member ID card, TTY **711**, 8 a.m. to 8 p.m., 7 days a week.

Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-844-752-9434**, TTY **711**.

Korean

참고: 한국어를 하시는 경우, 통역 서비스를 비용 부담 없이 이용하실 수 있습니다 **1-844-752-9434**, TTY **711** 로 전화하십시오.