SAV-RX
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 Reimbursement Form

For FFCRA-eligible OTC COVID-19 tests purchased on/after January 15, 2022, during the U.S. COVID-19 public health emergency
This Benefit is NOT available to Medicare-Eligible Retirees enrolled in the UnitedHealthcare Group Advantage Plan.

These items will be required for reimbursement:

1. **Proof of purchase** such as an original receipt from the pharmacy or a photo of the receipt for each Families First Coronavirus Response Act (FFCRA)-eligible OTC COVID-19 test kit expense listed below when submitting the form. **Receipt(s) should the purchase price and date of purchase.**
   - Credit card statements, canceled checks, estimated expenses, etc. are not valid documentation. Please see your Summary Plan Description for more details on the claims process. This reimbursement benefit is limited to 8 individual FFCRA-eligible OTC COVID-19 tests per covered person per month (a test kit package with 2 tests = 2 individual tests).
   - If the OTC COVID-19 tests were purchased from an out-of-network pharmacy, the test will be reimbursed the lesser of $12 per test in package or the purchase price.
   - If the OTC COVID tests were purchased from an in-network pharmacy, the test will be reimbursed the purchase price.
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 Test Kits: _____

Name(s) of OTC COVID-19 Test Kits: _____

UPC or NDC of each kit (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 the OTC COVID-19 test(s) were purchased while I was eligible for coverage, on or after January 15, 2022, and during the COVID-19 public health emergency declared by the Secretary of the U.S. Department of Health and Human Services (HHS); 3) 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* as a condition of employment or for employment purposes; 4) that the OTC COVID-19 test(s) have not been (and will not be) reimbursed by another source; and 5) 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_____