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_____