

# COVID-19 test kit reimbursement request form

Use this form to request reimbursement for FDA-authorized COVID-19 test kits purchased 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.

## Member Information

Rx Group: \_\_\_\_\_ Member ID# (see ID card): \_\_\_\_\_

Last Name: \_\_\_\_\_ First name: \_\_\_\_\_ M.I.: \_\_\_\_\_

Mailing street address: \_\_\_\_\_ Apt. # \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Test kit is for:  Self  Spouse  Dependent Date of birth: \_\_\_\_\_

## Custodial parent information: For reimbursement requests from a parent for a child

Legal custodian's name: \_\_\_\_\_

Legal custodian's contact phone: \_\_\_\_\_

Custodian requesting reimbursement name: \_\_\_\_\_

Custodian requesting reimbursement phone: \_\_\_\_\_

Address payment is to be mailed to: \_\_\_\_\_

## 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 (incl. tax and shipping): \_\_\_\_\_

## Reason for request

Reimbursement for FDA-authorized COVID 19 test kit

## 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 eight COVID 19 test kits.
2. Include the original receipt for each COVID-19 test kit
3. Read the Acknowledgement 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:  
**CareOregon**  
**315 SW 5th Avenue**  
**Portland, OR 97204**

**Note:** Incomplete forms may be returned and delay reimbursement. Reimbursement is not guaranteed. Claims are subject to plan's limits, exclusions and provisions.