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)
2. This form filled out and signed

To submit, please send this form with 1) the proof of payment, 2) the completed cardholder information, 3) the OTC COVID-19 test information, 4) and attestation 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

CARDHOLDER INFORMATION

Cardholder Name: _____

Card ID: _____

Group: _____

Telephone: _____

Address: _____ **City, State, Zip:** _____

OTC COVID-19 TEST INFORMATION

Name of Patient	Date of Birth	Purchase Date of OTC COVID-19 Test(s)	Number of Tests Purchased	UPC OR NDC (typically located near barcode)	Total Purchase Price
					$
					$
					$
					$
					$
					$
					$
					$
					$
					$

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_____