CVS caremark

Covid-19 Test Kit Reimbursement Claim Form

Important!

- Always allow up to 30 days from the time you receive the response to allow for claims processing and delivery.
- Keep a copy of all documents submitted for your records.
- Do not staple receipts or attachments to this form.
- Reimbursement is not guaranteed and other contractor will review the claims subject to limitations, exclusions and provisions of the plan.

STEP 1 Card Holder/Patient Information

This section must be fully completed to ensure proper reimbursement of your claim.

Card Holder Information

Identification Number (refer to your ID card)

Group Number/Group Name

Last Name

First Name

MI

Address

Address 2

City

State

Zip/Postal Code

Country

Patient Information–Use a separate claim form for each patient

Last Name

First Name

MI

Date of Birth

Phone Number

Relationship to Primary Member

Member ○ Spouse ○ Child ○ Other ○

Retailer Information

Retailer Name

continued

Important! A signature is REQUIRED

NOTICE

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, denial of benefits and/or imprisonment.

OTC test(s) were purchased for personal use, not employment, has not been reimbursed by another source, and is not for resale.

I certify that I (or my eligible dependent) have received the medicine described herein. I certify that I have read and understood this form, and that all the information entered on this form is true and correct.

x _____

Signature of Patient (REQUIRED) **Date**

STEP 2 Submission Requirements

You MUST include all original "pharmacy" or "cash register" receipts or on-line proof of purchase in order for your claim to process. The minimum information that must be included on your pharmacy or "cash register" receipts or on-line proof of purchase is listed below:

- Date of Purchase
- Price of Purchase
- Name of Covid-19 Test Kit

Name of Covid-19 Test Kit: _____

Number of Covid-19 Test Kits you are submitting for reimbursement: _____

Additional comments:

STEP 3 Mail completed forms with receipts to:

CVS Caremark
P.O. Box 53992
Phoenix, Arizona 85072-3992

CLEAR FORM