PINNACLE RxSolutions

AT-HOME COVID19 TEST KIT REIMBURSEMENT FORM

Please complete one form for EACH Member
Please refer to the "Submission Instructions" on Page 2 of this Document for receipt requirements

Reason for Reimbursement Request

- Reimbursement for an at-home, COVID19 specimen collection kit. Specimen was sent to an outside facility and results were interpreted by a lab or facility. **STOP:** Use the standard Medical Claim reimbursement form.
- Reimbursement for a COVID19 test that was administered by a physician or pharmacist
  STOP: Use the standard Medical Claim reimbursement form.
- Reimbursement for an at-home, over-the-counter rapid result test. Results interpreted by the consumer (**PROCEED)**

Cardholder Information:

HCID (Primary Insured's ID Number):	Employer Name:
Group# / Policy #:	Plan #:
Primary Insured's Name (Last, First, Middle):	Primary Insured's Birthdate (MM/DD/YYYY):
Primary Insured's Address (Street, City, State, Zip):	Primary Insured's Phone Number:

Patient Information – COVID-19 Test Kit Purchased for:

Member Name (Last, First, Middle):	Member Suffix (two digit number):	☐ Employee ☐ Spouse ☐ Dependent	Patient DOB (MM/DD/YYYY):

Retailer Information:

Retailer Name:	Date of Purchase:	Retailer Phone Number:
Retailer Address (Street, City, State, Zip):		

Test Kit Information:

Date Purchased:	Total Cost:	Test Name & Manufacturer:	
Boxes Purchased:	Quantity per Box:	NDC Code: *provide UPC code if the NDC is unavailable*	UPC Code:

Reimbursement Limits and Requirements:

- ☐ Test must be purchased on or after January 15, 2022
- ☐ 8 tests per member, per month.
- ☐ Maximum reimbursement at out of network pharmacies and retailers is $12 per test.
- ☐ Reimbursement submission must include purchase receipt that includes date of purchase, testing kit charges, and name of testing kit.

Customer Attestation

I certify that all information provided on this form is correct and that the test kit expenses submitted are for me or my eligible dependents. I understand that fraudulent acts (including false claims) may be subject to civil or criminal penalties. I also authorize release of eligible information pertaining to this claim(s) to the plan administrator, underwriter, plan sponsor, policyholder and/or employer.

Please check Yes or No for each of the following questions:

☐ Yes ☐ No		This test kit was purchased by the customer for personal use or the use of a covered plan member.
☐ Yes ☐ No		This test kit was purchased for employment purposes.
☐ Yes ☐ No		This test kit has been (or will be) reimbursed from another source.
☐ Yes ☐ No		This test kit has been (or will be) placed for resale.

Signature:	Date:

SUBMISSION INSTRUCTIONS

1. **SUBMISSION REQUIREMENTS:**

   Reimbursement Submissions Must Contain an Invoice or Receipt that Displays:

   - *The retailer where you purchased the home test kit, including physical address or website.*
   - *Date of service/purchase*
   - *Name of the Kit, NDC or UPC code for the home test kit*
   - *Cost*

2. **Completed Claims Forms can be mailed to:**

   Pinnacle Rx Solutions
   P.O. Box 2540
   Newport Beach, CA 92658-8944