COVID-19 FDA APPROVED OVER-THE-COUNTER TESTS

MEMBER REIMBURSEMENT FORM

Authorized U.S. Food & Drug Administration (FDA) tests are limited to 4 per member per month. Reimbursement is limited up to $12 per FDA approved over the counter test. A form will need to be submitted for each member, separately. Reimbursement may take up to 30 business days. Requests will be processed in the order in which they are received. Form for each individual should be filled out separately.

Member Name:	Member Date of Birth:
Member Address:	
Member ID#:	Group #:
Date Purchased:	Location Purchased:
Number of Tests Purchased: (limit 4 per member per month)	Name of Test(s) Purchased:
Reason for Test (REQUIRED):	_____Employment (not eligible for reimbursement) _____ Symptoms _____ Exposure _____ Other:_____

*Items Attached with Form (REQUIRED):

_____UPC label from each box/product ID

_____Receipt (showing date of purchase Must be dated 1/15/2022 or after, location purchased, cost and proof of payment – be sure to include a completed form for each member if submitting for multiple tests on the same receipt)

List of test kits eligible for reimbursement. The qualified product must have FDA emergency use authorization (EUA).

Product ID	Product Label	Product ID	Product Label
11877001140	Binaxnow Cov Kit Home Tes	82607066028	Flowflex Kit Test
16490002574	Clinitest Kit Self-Tst	56362000589	IHealth 2-pk Kit Covid-19
00111070752	Covid-19 At-Kit 1 Pack	56362000590	IHealth 5-pk Kit Covid-19
00111070772	Covid-19 At-Kit 4 Pack	08337000158	Inteliswab Kit Covid-19
56964000000	Ellume Covid19 Kit Home Te	60006019166	On/Go Covid Kit Antigen
50021086001	Ellume Cov19 Kit Home Tes	14613033972	Quickvue Hom Kit Covid-19
82607066026	Flowflex Kit Home Tst	14613033968	Quickvue Hom Kit Covid-19
82607066027	Flowflex Kit Test		

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD. I VERIFY THAT ALL INFORMATION CONTAINED IN THIS FORM IS TRUE, CORRECT, AND COMPLETE TO THE BEST OF MY KNOWLEDGE. IN ORDER TO PROCESS A CLAIM FOR BENEFITS I HEREBY AUTHORIZE ALL INDIVIDUALS OR INSTITUTIONS HAVING INFORMATION AS TO THE CARE, ADVICE, TREATMENT, DIAGNOSIS, OR PROGNOSIS OF ANY PHYSICAL OR MENTAL CONDITION, OR THE FINANCIAL AND EMPLOYMENT STATUS, OR THE PATIENT, EMPLOYEE, OR NAMED BELOW, TO PROVIDE THIS INFORMATION TO AULTCARE OR ANY AGENT OR INDEPENDENT ADMINISTRATOR ACTING ON ITS BEHALF (INCLUDING RECORDS). I UNDERSTAND THAT I HAVE THE RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION UPON REQUEST. A COPY OF THIS SHALL BE AS VALID AS THE ORIGINAL. BY SIGNING BELOW, I AM ATTESTING THAT I AM SEEKING REIMBURSEMENT FOR INDIVIDUALIZED MEDICAL ASSESSMENT.

DATE:	**SIGNATURE OF MEMBER OR AUTHORIZED REPRESENTATIVE:**

**Form needs to be completed in its entirety, including required items to receive reimbursement.*

Submit form and all attachments to:

AultCare Pharmacy Department, P.O. Box 6910, Canton OH 44706

- P.O. Box 6910 | Canton, OH 44706
- PHONE: 330-363-6360 | TOLL FREE: 1-800-344-8858
- TTY LINE: 711
- WEBSITE: www.aultcare.com