CerpassRx
5904 Stone Creek Drive, Ste.120
The Colony, TX 75056
1-844-636-7506
www.cerpassrx.com

Covid 19 - At Home Testing
Direct Reimbursement Claim Form

When to use this from:

This claim form is to be used only when you have purchased the full cost of Covid 19 testing kit(s) and are requesting reimbursement with a valid receipt on or after 1/15/2022.

Please fill out the necessary information below and include your valid purchase receipt with this form. Payments will be processed within 4 to 6 weeks of receipt.

Instructions:

- The purpose of this form is for you to request reimbursement for out-of-pocket purchases of the Covid 19 test kits without using your health plan card or other reasons approved by your health plan.
- To process your request within 4 to 6 weeks after receiving your request, it is important to complete all the information including your valid receipt.
- Please use a separate form for each individual patient.

Patient Information
Member ID Number:
Group Number:
Patient Name:
Date of Birth:
Patient Address:
Patient Telephone Number:
Name of Legal Representative (If applicable):

I certify that the above information is correct and that the above checked person is eligible for benefits. I have received the OTC, at-home COVID-19 test(s) described hereon and authorize release of all information contained on this voucher to CerpassRx and the underwriter. I agree that any benefits payable hereunder for OTC, at-home COVID-19 self-tests are not assignable and that any assignment or attempted assignment thereof shall be void.

I further represent that there has been no assignment of benefits hereunder. I certify that the OTC, at home COVID-19 test(s) that I am submitting for reimbursement on this form (1) were bought for personal use by the patient listed above, (2) were not bought for employment purposes, (3) have not been and will not be reimbursed by another source, and (4) are not for resale.

_____ _____

Patient Signature or Legal Representative Date

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Purchased Information Section:

Pharmacy Purchased location	Rx Number - if available	Date purchased	
Number of kits	Manufacturer name(s)		
If issued by Doctor- Physician Name	Physician NPI		Total Paid

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Number of kits	Manufacturer name(s)		
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To process your request for reimbursement, it is necessary that you include the following documents:

- The original paid receipt(s) must accompany this form. A cash register or charge receipt is acceptable. Handwritten receipts are not acceptable.
- If you no longer have original receipt(s) please ask your purchase provider or pharmacy to give you a printout copy or receipt.
- Please allow 4 to 6 weeks for processing and payment of your claims(s). Claim forms submitted without the required information will be returned and/or will cause payment delay.

If you have any questions, please contact our customer service center at 1-844-636-7506.

Remember to sign the direct Covid19 reimbursement form and send original receipts.

You have three options to submit your request:

1. **Send form and original receipt(s) to:**
   CerpassRx
   5904 Stone Creek Drive
   Ste.120
   The Colony, TX 75056

2. **Fax form and photo of receipt(s) to:**
   Fax # (469) 533-9967

   or

3. **Email form and photo of receipt(s) to:**
   manualclaims@cerpassrx.com