



COVID 19 TEST KIT REIMBURSEMENT REQUEST FORM

Use this form to request reimbursement for FDA-authorized COVID-19 test kits purchased on or after January 15, 2022 at a retail store, pharmacy or online retailer. Reimbursement requests take up to 4-6 weeks to process.

Complete one form per member. Please print clearly.

1 Member information

RxGroup (see ID card)

Member ID (see ID card)

Last name

First name

MI

Mailing street address

Apt. #

City

State

ZIP

Test Kit(s) is for Self Spouse Dependent

Date of Birth (mm/dd/yyyy)

2 Purchase information

Name of pharmacy, store or online retailer

Pharmacy/Retailer address

Date of purchase

Product name

Number of tests requesting reimbursement

Total cost of purchase (including applicable tax & shipping)

3 Reason for request

Reimbursement for FDA-authorized COVID 19 test kit

4 Acknowledgement

I certify that the OTC COVID-19 test kits for which reimbursement is requested were received for use by the patient above, and that I (or the patient, if not myself) am eligible for benefits. I also certify that the test kits received were not for employment-related COVID-19 testing requirements.

Signature: _____ **Date:** _____

Instructions for submitting form

1. Covered member can submit a monthly claim form for up to (8) COVID 19 test kits or as defined by your State benefit.
2. Include the original receipt for each COVID-19 test kit
3. Read the Acknowledgement (section 4) on the front of this form carefully. Then sign and date. Print page 2 of this form on the back of page 1.
4. Send completed form with pharmacy receipt(s) to: OptumRx Claims Department, PO Box 650334, Dallas, TX 75265-0334

Note: Incomplete forms may be returned and delay reimbursement. Reimbursement is not guaranteed. Claims are subject to your plan's limits, exclusions and provisions.

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 and/or imprisonment, or denial of benefits.



NOTICE OF NON-DISCRIMINATION

UnitedHealthcare Community Plan complies with Federal civil rights laws. UnitedHealthcare Community Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

UnitedHealthcare Community Plan provides the following:

- Free aids and services to people with disabilities to help you communicate with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose first language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, please call the toll-free member phone number listed on your member ID card.

If you believe that UnitedHealthcare Community Plan has not given you these services or treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with Civil Rights Coordinator by:

Mail: Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130

Email: **UHC_Civil_Rights@uhc.com**

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by:

Web: Office for Civil Rights Complaint Portal at
<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Mail: U.S. Dept. of Health and Human Services
200 Independence Avenue SW, Room 509F, HHH Building
Washington, D.C. 20201

Phone: Toll-free 1-800-368-1019, 1-800-537-7697 (TDD)

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call Member Services at **1-800-493-4647**, TTY **711**, 8 a.m. – 6 p.m., Monday – Friday.



NOTIFICACIÓN DE LA NO-DISCRIMINACIÓN

UnitedHealthcare Community Plan cumple con los requisitos fijados por las leyes Federales de los derechos civiles. UnitedHealthcare Community Plan no excluye a las personas o las trata de manera diferente debido a su raza, color, nacionalidad, edad, discapacidad o sexo.

UnitedHealthcare Community Plan provee lo siguiente:

- Asistencia y servicios gratuitos de ayuda para las personas con discapacidades en su comunicación con nosotros, con:
 - Intérpretes calificados en el lenguaje de señas
 - Información por escrito en diferentes formatos (letras de mayor tamaño, audición, formatos electrónicos accesibles, otros formatos)
- Servicios gratuitos con diversos idiomas para personas para quienes el inglés no es su lengua materna, como:
 - Intérpretes calificados
 - Información impresa en diversos idiomas

Si usted necesita estos servicios, por favor llame gratuitamente al número anotado en su tarjeta de identificación como miembro.

Si usted piensa que UnitedHealthcare Community Plan no le ha brindado estos servicios o le han tratado a usted de manera diferente debido a su raza, color, nacionalidad, edad, discapacidad o sexo, puede presentar una queja ante el Coordinador de los Derechos Civiles (Civil Rights Coordinator) haciéndolo por:

Correo: Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130

Correo electrónico: **UHC_Civil_Rights@uhc.com**

Usted también puede presentar una queja acerca de sus derechos civiles ante el Departamento de Salud y Servicios Humanos de los Estados Unidos, Oficina de Derechos Civiles, por:

Internet: Sitio en internet para la Oficina de Derechos Civiles en
<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Correo: U.S. Dept. of Health and Human Services
200 Independence Avenue SW, Room 509F, HHH Building
Washington, D.C. 20201

Teléfono: Gratuitamente al 1-800-368-1019, 1-800-537-7697 (TDD)

Ofrecemos servicios gratuitos para ayudarle a comunicarse con nosotros. Tales como, cartas en otros idiomas o en letra grande. O bien, puede solicitar un intérprete. Para pedir ayuda, por favor llame a Servicios para Miembros al **1-800-493-4647**, TTY **711**, 8 a.m. a 6 p.m., de lunes a viernes.

LANGUAGE ASSISTANCE

ATTENTION: Language assistance services, free of charge, are available to you. English
 Call 1-800-493-4647 TTY 711

ATTENTION: Language assistance services, free of charge, are available to you. Call 1-800-493-4647 TTY 711.	English
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-493-4647 TTY 711.	Spanish/Español
注意：您可以免費獲得語言援助服務。請致電 1-800-493-4647 TTY 711。	Chinese/中文
ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-493-4647 رقم هاتف الصم والبكم TTY 711	Arabic/اللغة العربية
주의: 무료 언어 지원 서비스를 이용하실 수 있습니다. 1-800-493-4647 TTY 711로 전화하시기 바랍니다.	Korean/한국어
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-493-4647 (телетайп: TTY 711).	Russian/Русский
ATTENZIONE: Nel caso in cui la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il 1-800-493-4647 TTY 711.	Italian/Italiano
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-493-4647 TTY 711.	French/Français
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-493-4647 TTY 711.	French Creole/ Kreyòl ki soti nan Fransè
אכטונג: אויב איר רעדט אידיש, זענען פאראן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-800-493-4647 TTY 711	Yiddish/אידיש
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-493-4647.	Polish/Polski
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyong pantulong sa wika nang walang bayad. Tumawag sa 1-800-493-4647 TTY 711	Tagalog
দৃষ্টি আকষণ: যদি আপনার ভাষা "Bengali বাংলা" হয় তাহলে আপনি বিনামূল্যে ভাষা সহায়তা পাবেন। 1-800-493-4647 TTY 711 নম্বরে ফোন করুন।	Bengali/বাংলা
KUJDES: Ju vendosen në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-493-4647	Albanian/Shqip
Προσοχή: Στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε «1-800-493-4647» TTY 711.	Greek/ Ελληνικά
توجه دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان سے متعلق مدد کی خدمات مفت دستیاب ہیں۔ کال کریں 1-800-493-4647 TTY 711	Urdu/اردو

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