Prescription Drug Claim Form - COVID19 At-Home Test Kit

Capital Rx

Important: Please read instructions prior to completing this form. Only COVID19 At-Home Test Kits purchased on or after January 15, 2022 can be considered for reimbursement. Plan coverage is limited to 8 tests, per covered individual within a 30 day period.

Policyholder:

1. Present your prescription drug card at the pharmacy to avoid having to submit a paper claim for reimbursement. If necessary, use this form for prescription claims purchased without using your drug card.
2. For a list of participating pharmacies in your area, please refer to our website at www.cap-rx.com or call the Customer Service number on the back of your Prescription Drug Card.
3. Please provide all information requested in **Section 1** for both the patient and policyholder.
4. Sign and date the form in the area provided.
5. For submissions to be processed, the following articles of documentation are required:
   - Completed form.
   - Photo of the COVID19 At-Home Test Kit package with the barcode visible.
   - Cash register receipts with date of purchase visible. Please note - for receipts with more than one line item listed, please circle or highlight the COVID19 At-Home Test Kit line item for ease of processing.
6. Mail complete submissions to: Capital Rx, Inc. Attn: Claims Dept., 228 Park Avenue South, Suite 87234, New York, NY 10003.

Please note: *Incomplete forms may be returned and/or delay the process. Please make copies of all documents for your own records. Once your submission is successfully processed, you will be reimbursed directly for all covered services up to the allowed amount. Reimbursement is not guaranteed and are subject to your plan's limits, exclusions and provisions.**

SECTION 1

1. Policyholder or Insured Name (First, Middle, Last) _____

   Address _____ State _____ Zip Code _____

   City _____
2. Policyholder or Insured ID No. (as shown on ID Card) _____
3. Why was the insurance or drug card not used for this purchase? _____
4. Plan or Employer Name _____
5. Patient's Name (First, Middle, Last) _____
6. Patient's Birth Date _____
7. Patient's Relationship to Policyholder ☐ Self ☐ Spouse ☐ Child ☐ Other Dependent

I certify that the information on this claim form is correct to the best of my knowledge. I authorize the release of any medical information pertaining to this claim to Capital Rx.

Signature _____ Date _____

***Important:** Payment for the above claim(s) will be made directly to the Policyholder. Any assignment of these benefits must include the signature of the Policyholder and is subject to Capital Rx's approval.*

***Insurance Fraud Warning:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the appropriate state agency within the department of regulatory agencies.*