Maxor
PHARMACY BENEFIT MANAGEMENT SERVICES

MaxorPlus Over-the-Counter (OTC), At-Home COVID Test Reimbursement Form

YOUR CLAIM CANNOT BE PROCESSED IF THIS FORM IS INCOMPLETE.

Plan Member Name _____
First Middle Last

Patient Name _____
First Middle Last

_____ _____ _____ Patient's Date of Birth ☐☐ ☐☐ ☐☐☐☐ Patient: Sex M F
Plan Member ID Number Patient Code Group Number mm dd yyyy (Circle One)

Plan Member Address _____
Street City State Zip

_____ _____
Employer Name Insurance Company

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 MaxorPlus 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.

_____
Plan Member Signature

Please complete the remaining portion of this form: **YOUR CLAIM CANNOT BE PROCESSED UNLESS THIS FORM IS COMPLETE**
(You must attach a copies of receipts in order for this form to be considered complete.)

Place of Purchase:	**Place of Purchase:**	**Place of Purchase:**
Date Purchased:	**Date Purchased:**	**Date Purchased:**
NDC # on the Package:	**NDC # on the Package:**	**NDC # on the Package:**
# of Packages Purchased:	**# of Packages Purchased:**	**# of Packages Purchased:**
Quantity of Tests per Package:	**Quantity of Tests per Package:**	**Quantity of Tests per Package:**
Price Paid per Package:	**Price Paid per Package:**	**Price Paid per Package:**
Brand Name:	**Brand Name:**	**Brand Name:**

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Please Read Carefully Before Completing This Form

Use this claim form to request reimbursement for OTC, at-home COVID-19 tests purchased:

When filling out claim forms:

* Complete a separate form for each family member for whom OTC, at-home COVID-19 tests were purchased.
* Complete the top portion of the form in full. Incomplete forms will be returned to you for completing.
* Include these numbers from your prescription card:
  > Plan member's (insured) ID number
  > Patient code: two-digit number assigned to individual family member (listed on card)
* Include a copy of your receipt.

If you have any questions, please call: MaxorPlus Customer Service at (800) 687-0707.

FOLD WITH ADDRESS ON OUTSIDE, AFFIX POSTAGE AND MAIL

Patient Reimbursement Claims

MAXORPLUS

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