Appro-Rx
415 S. Main St.
Waynesville, OH 45068
Email Claim Form to: info@approrx.com

# COVID 19 At Home Test Kits – Claims Form

**Group #:**

**Employer:**

| Patient Information |
|---|
| Patient Name: |
| Patient's Relationship to Cardholder: |
| Patient's Address: *Street* *City* *State* *Zip* |
| Patient's Date of Birth: |
| Home Phone Number: Member ID Number: |

**Required Attachment:**

This form serves as a **health claim**. *Submit a receipt for proof of purchase with the following information:*

- ✓ Pharmacy/Retailer Name
- ✓ Date of Service/Date of Purchase
- ✓ Price For Test
- ✓ UPC Code/NDC for the OTC COVID-19 Test
- ✓ Number of Boxes/Tests (usually it is two tests per box)
- ✓ Paid Amount

** Excessive charges subject to review and denial, with the presumption* of *reasonable* being $*12.00* per *test."*

The above statements are true and complete to the best of my knowledge and belief. I attest that the COVID 19 test is not used for employment purposes, has not and will not be reimbursed by another source, and is not for resale. Any person who knowingly, and with the intent to defraud or deceive any insurance company, files an application or claim containing any false, incomplete, or misleading information will be held responsible to the fullest extent of the law to and including termination of participation in the health plan and/or prosecution.

Patient/Legal Guardian Signature_____Date_____