SGRX COVID-19 At-Home Test Kit Direct Member Reimbursement Form

Directions: **(Please read carefully and fill out the entire form.)**

1) This form **must** be completely filled out in order to process your claim(s).
2) Attach *all* receipt(s) to the back of this form.
3) **Receipts must contain *all* of the following information *or* they will not be accepted: Date filled, Test Kit Name with NDC or UPC number, Quantity and Cost.**

4) Sign the form and mail with receipts to: **SGRX**
15400 East Jefferson Avenue
Grosse Pointe Park, MI 48230

If you have any questions/concerns please call member services at:
855-855-SGRX (7479) ♦ Monday – Friday: 8:30AM to 5:00PM EST

Please allow 4 weeks from the time you mail your request .

Member Information: (This is the individual for whom the testing kit is for).
Please Print

Member Name_____ _____
Member's Contact Phone Number

Mailing Address_____

City _____ State _____Zip Code_____ _____
Member ID Number (as it appears on Rx card)

_____ _____
Sex: Male/Female Date of Birth

Test Kit Information:

RxNumber (not required)	Date Purchased	Name and Address Where Test was Purchased	Kit Name and NDC or UPC #	Strength (not required)	Quantity	Days Supply (not required)	Amount Paid

***** Are these reimbursement(s) for Secondary Coverage ? YES NO .
Please Circle

I hereby certify that the above statements, including accompanying statements, are to the best of my knowledge true, correct, and complete. I hereby authorize any physician or service provider to furnish and disclose all known facts concerning this claim(s) upon request from the claims administrator. I will reimburse the fund for any overpayment made to me or on my behalf due to error on this form.

MEMBER SIGNATURE:_____ **DATE:**_____