Documentation of Request- Medicare and Commercially-Insured Patient Request and Attestation for OTC COVID-19 Test Billing *(Please print clearly)*

Date Requested:_____ Method of Request: ☐ In-person ☐ Los Gatos Employee ☐ Other:_____

Last Name:	**First Name:**	**MI:**	SSN (optional):
Date of Birth (mmddyyyy):	**Age:**	**Gender:**	Need Interpreter: ☐ Yes ☐ No
Home Address:	**City:**	**State:**	**Zip:**
Cell Phone #:	Email:		ECH EMPLOYEE #:
Medicare Beneficiary Number (Part B):			
Insurance Name:	RX BIN#:	RX PCN#:	
RX Insurance ID #:	RX Insurance Group #:		

OTC COVID-19 TEST Requested: ☐ 8 tests ☐ 4 tests ☐ Other: _____

Note: *Max quantity requested cannot exceed 8 tests per covered family member on your plan, per calendar month, regardless of which provider you received the test from.*

ATTESTATION AND CONSENT

I have requested the pharmacy to provide the above listed OTC COVID-19 tests and attest to the following:

- The tests requested above are for personal use for the indicated patient
- I agree not to resale the tests provided under this covered benefit
- The cost of these tests is not being covered by any other source
- I have not requested OTC COVID-19 tests from another provider in the current calendar month
- I consent that the pharmacy may message me via Text message or RxLocal app when my order is ready

ALL RECIPIENT MUST COMPLETE THIS SECTION.

Print Name:_____ Signature: _____

Relationship:_____ Date: _____

If recipient is a minor- the Parent, guardian, or authorized representative please print your name and sign above

*******BELOW FOR PHARMACY USE ONLY *******

Name of OTC COVID-19 Test being supplied:

☐ FLOWFLEX ☐ I-HEALTH ☐ QUICKVUE ☐ _____

Sig: Test as directed per manufacturer and CDC guidance

No Refills

Pharmacist on Duty: _____

Outpatient Pharmacy Fax- 650-988-8245

Affix Rx label