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

Date Requested:_____ **Request by:** ☐ In-person/MV Employee ☐ Los Gatos Employee
☐ MV Night-Shift 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 #:
Medical Beneficiary Number:			
Insurance Name:	RX BIN#:	RX PCN#:	
RX Insurance ID #:	RX Insurance Group #:		

OTC COVID-19 TEST Requested: ☐ 8 tests

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: _____

ALL recipient must sign; if a minor- the Parent, guardian, or authorized representative please print your name and sign above

IF YOU NEED A PRESCRIPTION TRANSFERRED FROM ANOTHER PHARMACY, PLEASE COMPLETE THE INFORMATION BELOW; WE WILL OBTAIN THE TRANFER FROM THE OTHER PHARMACY:

PHARMACY NAME: _____PHARMACY PHONE:_____

PRESCRIPTION NUMBER(S) / NAME OF MEDICATION(S):_____

_____

_____

OTHER INSTRUCTIONS: _____

*****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 **v. 122123**