Medicare and Commercially-Insured Patient Request and Attestation for OTC COVID-19 Test Billing

Documentation of Request

Date Requested: _____

Method of Request: ☐ In person ☐ Telephone ☐ Other: _____

Person Requesting: _____

Request #	Patient Name	Beneficiary DOB	Quantity Requested	Relationship to patient	Quantity of On-Hand Supply Remaining
Sample	*John Doe*	*1/1/1950*	*8*	*Self*	*0*
1					
2					
3					
4					
5					

Attestation

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(s)
- These tests are not for employer or travel purposes
- 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

Signature of patient (or legal representative): _____

Name: _____ **Date:** _____

----------Pharmacy Only Claim Information----------

Name of OTC COVID-19 Test being supplied: _____

Sig: Test as directed per manufacturer and CDC guidance

No Refills

Pharmacist on Duty: _____