

# 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
<i>Sample</i>	<i>John Doe</i>	<i>1/1/1950</i>	<i>8</i>	<i>Self</i>	<i>0</i>
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: \_\_\_\_\_

**Disclaimer:** PAAS National® does not assume any legal liability or responsibility for the completeness, or usefulness, of this documentation. The information contained herein was developed based on CMS/PBM requirements at the time of its creation and may not meet all PBM/payor requirements. If pharmacies are initiating a prescription, confirm that all required elements of a prescription are present for your state.