Phone Number: ()	Name:	
☐ ID check ☐ Self  PATIENT USE ONLY:  My pharmacy dispensed the COVID-19 tests to me today with an offer to counsel.  Qty Requested: Qty: 1 ☐, 2 ☐, 3 ☐, 4 ☐, 5 ☐, 6 ☐, 7 ☐, 8 ☐  My signature below authorizes assignment of direct payment to the pharmacy any amounts which may be covered by my insurance.	DOB:	
COVID-19 OTC Home Test    FlowFlex (1ea) NDC: 82607-0660-26  Qty: 8	Phone Number: ()	_
□ FlowFlex (1ea) NDC: 82607-0660-26  Qty: 8 □ Initial: (MAX IS 8) (Check Qty Requested)  Day supply should match quantity submitted  Sig: For personal use only. Not for employment purposes or for resale. Refills: 0  PHARMACY USE — MPB CLAIMS ONLY: □ ID check □ Self  PATIENT USE ONLY:  My pharmacy dispensed the COVID-19 tests to me today with an offer to counsel.  Qty Requested: Qty: 1 □, 2□,3□, 4□, 5□, 6□, 7□, 8□  My signature below authorizes assignment of direct payment to the pharmacy any amounts which may be covered by my insurance.	Address:	
Qty: 8		
Initial:		
(MAX IS 8) (Check Qty Requested)  Day supply should match quantity submitted  Sig: For personal use only. Not for employment purposes or for resale. Refills: 0  PHARMACY USE — MPB CLAIMS ONLY:  Did check Self  PATIENT USE ONLY:  My pharmacy dispensed the COVID-19 tests to me today with an offer to counsel.  Qty Requested: Qty: 1 , 2 , 3 , 4 , 5 , 6 , 7 , 8   My signature below authorizes assignment of direct payment to the pharmacy any amounts which may be covered by my insurance.	Qty: 8 □	
Day supply should match quantity submitted  Sig: For personal use only. Not for employment purposes or for resale. Refills: 0  PHARMACY USE – MPB CLAIMS ONLY:    ID check   Self  PATIENT USE ONLY:  My pharmacy dispensed the COVID-19 tests to me today with an offer to counsel.  Qty Requested: Qty: 1  , 2 , 3 , 4 , 5 , 6 , 7 , 8   My signature below authorizes assignment of direct payment to the pharmacy any amounts which may be covered by my insurance.	Initial:	
Sig: For personal use only. Not for employment purposes or for resale. Refills: 0  PHARMACY USE – MPB CLAIMS ONLY:  ID check Self  PATIENT USE ONLY:  My pharmacy dispensed the COVID-19 tests to me today with an offer to counsel.  Qty Requested: Qty: 1 □, 2□,3□, 4□, 5□, 6□, 7□, 8□  My signature below authorizes assignment of direct payment to the pharmacy any amounts which may be covered by my insurance.	(MAX IS 8) (Check Qty Requested)	
PHARMACY USE – MPB CLAIMS ONLY:    ID check   Self    Self    PATIENT USE ONLY:  My pharmacy dispensed the COVID-19 tests to me today with an offer to counsel.  Qty Requested: Qty: 1   2, 2   3, 4   5   6   7   8    My signature below authorizes assignment of direct payment to the pharmacy any amounts which may be covered by my insurance.	Day supply should match quantity submi	tted
☐ ID check ☐ Self  PATIENT USE ONLY:  My pharmacy dispensed the COVID-19 tests to me today with an offer to counsel.  Qty Requested: Qty: 1 ☐, 2☐,3☐, 4☐, 5☐, 6☐, 7☐, 8☐  My signature below authorizes assignment of direct payment to the pharmacy any amounts which may be covered by my insurance.	Sig: For personal use only. Not for employed	oyment purposes or for resale. Refills: 0
My pharmacy dispensed the COVID-19 tests to me today with an offer to counsel.  Qty Requested: Qty: 1 \( \to \), 2 \( \to \), 3 \( \to \), 4 \( \to \), 5 \( \to \), 6 \( \to \), 7 \( \to \), 8 \( \to \)  My signature below authorizes assignment of direct payment to the pharmacy any amounts which may be covered by my insurance.	☐ ID check	
Qty Requested: Qty: 1 \(\top_1\), 2\(\top_1\), 4\(\top_1\), 5\(\top_1\), 6\(\top_1\), 7\(\top_1\), 8\(\top_1\)  My signature below authorizes assignment of direct payment to the pharmacy any amounts which may be covered by my insurance.	PATIENT USE ONLY:	
My signature below authorizes assignment of direct payment to the pharmacy any amounts which may be covered by my insurance.	My pharmacy dispensed the COVID-19 t	ests to me today with an offer to counsel.
which may be covered by my insurance.	Qty Requested: Qty: $1 \square$ , $2\square$ , $3\square$ , $4\square$ , $5\square$	50,60,70,80
Patient Signature: Date:		
	Patient Signature:	Date: