Name: _____

DOB: _____

Phone Number: (_____) _____-_____

Address: _____

COVID-19 OTC Home Test

❑ **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.

Patient Signature: _____ Date:_____