MyNuRx
Nutritional Pharmacy
Compounding, Health & Wellness Center

OTC COVID-19 TEST REQUEST TO BILL INSURANCE

I, _____ (Printed First and Last Name), am requesting from NuRx Pharmacy LLC, _____(Number of OTC Test). I am requesting that they submit my insurance for payment for these tests. I certify that I have not received any test from any other location to bill my insurance. I understand that if my insurance denies the claim for any reason I will be responsible for the payment of the test at the Medicare Contracted Rate of $12 per test. I must present my insurance card and for Medicare, the Original Medicare Card must be presented to NuRx Pharmacy for payment.

I must also bring an alternative form of payment to pay NuRx Pharmacy in case the claim is denied from the insurance company and I will be required to pay. NuRx Pharmacy will call the listed number below to notify the responsible person to bill the credit or debit card prior to doing the transaction. If the responsible party does not answer a voicemail will be left, if the mailbox is full this will be considered as leaving a voice message.

I understand all the above statements and will be responsible for payment if my insurance does not cover the claim.

_____

Patient Signature Date

_____

Patient Name Gender Date of Birth

_____

Address City State Zip Phone Number