Complete and print.

Reset Form

MAYO CLINIC

At-Home COVID-19 Test Request

Pharmacy

Form content not retained in medical record.
For local storage only.

(complete fields or place patient label here)

Patient Name *(First, Middle, Last)*	
Birth Date *(mm-dd-yyyy)*	Room Number (if applicable)
Mayo Clinic Number	

For use only by patients with Mayo Medical Plan or other Alluma prescription coverage to request over-the-counter, FDA-approved COVID-19 rapid antigen home tests at no charge.

Instructions: Fill out this form completely. You may fill this out electronically or by hand. If filling out by hand, print legibly using black ink only. Use a separate form for each patient and for each request. Submit using one of these options:

Mail: Mayo Clinic Pharmacy Mail Service
RO_TF_1-300
200 First Street SW
Rochester, MN 55905

Fax: 507-284-5824

Email: MCPCOVIDTestOrders@mayo.edu

Request Information

Shipping Address	City	State	ZIP Code
Daytime Phone (with area code)	Email (for notification)		
Number of Tests Requested (up to 8 tests per month allowed) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8			

Terms and Conditions

- I am covered under Mayo Medical Plan or other Alluma prescription coverage. If I do not have this coverage, an at-home COVID-19 test will **not** be mailed.
- Allow 7–10 business days for delivery. Incomplete information may cause delivery to be delayed beyond 10 days.
- No shipping or handling charges apply to orders shipped via US Mail.

Signature

The information I have provided is correct, and I understand and accept the terms and conditions.

Patient Signature (required) ▶	Date *(mm-dd-yyyy)*

Digital/typed signatures are acceptable.

Print

ENTERPRISE: Applies to Mayo Clinic locations in Arizona, Florida, Rochester and Mayo Clinic Health System.