



Universal Claim Form for a Compounded Medication

Recognized by the International Academy of Compounding Pharmacists

Patient

Pharmacist

Cardholder

Prescriber

Pharmacy Information			Pharmacist's Name			Date		
Phone			Pharmacist's License #			NABP #		
			Pharmacist's Signature			State ID #		
Name			Telephone			Name		
Address			Address			Address		
City			State			Zip		
City			State			Zip		
Birthdate		Sex	Social Security/Subscriber I.D. No.					
Birthdate		Sex	Social Security/Subscriber I.D. No.					
Patient's Relationship to Cardholder						Employer		
Employer						Employer ID		
Group No.						Plan No.		

Patient Authorization

I hereby authorize release of information to health care providers, institutions, and/or payers that may pertain to my illness and/or treatment received. I certify that the information I have reported with regard to my insurance coverage is correct, and I have received the pharmacist care/services rendered.

X

Patient Signature

X

Date

Medication Name				Price			
Prescription Number		Days Supply		Date Filled		Quantity Dispensed	
Rx #							
Dosage Form				Strength			
Ingredients							
Prescriber's Name				Prescriber's DEA		Prescriber's NPI	
DAW:							

Pharmacist Authorization

I hereby certify that the above compounded medication was ordered by the stated prescriber specifically for the stated patient. This medication is not commercially available in this formulation or dosage form. The compounding was done using the highest possible standards, pure chemicals or drugs

Because this prescription is compounded and not manufactured, an NDC number is not required for reimbursement.

X

Pharmacist Signature

X

Date:

If you have difficulty in submitting this form or receiving payment from your insurance company, please contact us, your employer benefits manager, or the State Insurance Commissioner: