Universal Claim Form for a Compounded Medication

Recognized by the International Academy of Compounding Pharmacists

Pharmacist

Pharmacy Information	Pharmacist's Name		Date
Phone	Pharmacist's License #	NABP #	NPI
	Pharmacist's Signature X	State ID #	

Patient

Name			Telephone
Address			
City		State	Zip
Birthdate	Sex	Social Security/Subscriber I.D. No.	
Patient's Relationship to Cardholder			

Cardholde

Name			Telephone
Address			
City		State	Zip
Birthdate	Sex	Social Security/Subscriber I.D. No.	
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 ______________________ X __________

Patient Signature Date

Prescription

Medication Name			Price
Prescription Number Rx #	Days Supply	Date Filled	Quantity Dispensed
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 ______________________ X __________

Pharmacist Signature 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: