



Universal Claim Form for a Compounded Medication[®]

Recognized by the International Academy of Compounding Pharmacists

PHARMACY INFORMATION	Pharmacist's Name		Date	
	Pharmacist's License #		NABP#	
	Pharmacist's Signature		State ID#	
Name	Telephone	Name	Telephone	
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 I.D.	
		Group No.	Plan No.	
Patient Authorization				
<p>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.</p>				
		Patient Signature	Date	
<p>I hereby authorize my Pharmacy (in either case, "Pharmacy") to execute on my behalf any assignment of benefits documents required to permit my insurer to make payment directly to Pharmacy or its assigns. I understand that any amounts not paid by insurer because of deductible clauses, lack of coverage, or refusal to accept assignment of benefits shall be my responsibility.</p>				
		Patient Signature	Date	
Medication Name			Price	
Prescription Number	Days Supply	Date Filled		
Dosage Form		Strength		
Active Ingredients		Quantity Dispensed		
Prescriber's Name		DEA #		
Pharmacist Authorization				
<p>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 and contemporary technology. Because this prescription medication is compounded and not manufactured, an NDC number is not required for reimbursement.</p>				
		Pharmacist Signature	Date	
<p><i>If you have difficulty in submitting this form or receiving payment from your insurance company, please contact us, your employee benefits manager, or the State Insurance Commissioner at _____</i></p>				

Patient Information

Pharmacist

Cardholder Information

Prescription Information