# NCPDP Universal Claim Form Sample

## NAME
- **Patient**: Theresa Hart
- **Provider**: Planned Parenthood of Hawaii

## Address
- **Address**: Planned Parenthood of Hawaii
- **State & Zip Code**: Planned Parenthood of Hawaii

## Claim Form Information
- **Date of Injury**: [MM DD YYYY]
- **Date Submitted**: [MM DD YYYY]
- **Identification Code**: [DI][[0100] 100]

## Prescription Information

<table>
<thead>
<tr>
<th>Item</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Product/Service ID</strong>:</td>
<td>[DI][[0100] 100]</td>
</tr>
<tr>
<td><strong>Provider ID</strong>:</td>
<td>[DI][[0100] 100]</td>
</tr>
<tr>
<td><strong>Diagnosis Code</strong>:</td>
<td>[DI][[0100] 100]</td>
</tr>
<tr>
<td><strong>Other Payer Date</strong>:</td>
<td>[DI][[0100] 100]</td>
</tr>
<tr>
<td><strong>Other Payer ID</strong>:</td>
<td>[DI][[0100] 100]</td>
</tr>
</tbody>
</table>

## Claim Details
- **Prescription/Service: [DI][[0100] 100]**
- **Date Written**: [DI][[0100] 100]
- **Date of Service**: [DI][[0100] 100]
- **Filler**: [DI][[0100] 100]
- **City Dispensed**: [DI][[0100] 100]
- **Date of Last Fill**: [DI][[0100] 100]

## Claim Information
- **Prescription/Service**: [DI][[0100] 100]
- **Date Written**: [DI][[0100] 100]
- **Date of Service**: [DI][[0100] 100]
- **Filler**: [DI][[0100] 100]
- **City Dispensed**: [DI][[0100] 100]
- **Date of Last Fill**: [DI][[0100] 100]

## Notes
- Please note that the information provided is a sample and not intended for actual submission or processing.

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**Attention Recipient:**
Please read and accept the terms listed below.

**Patient Authorization:**
I have read the Certificate of Coverage and the terms thereof. I hereby certify that I have signed 1 or 2 (please circle number) prescription(s) listed below.

**Certification Statement:**
I certify that the information provided is true and accurate to the best of my knowledge.

**ReveriSe SOT:**
Any changes or corrections should be noted on the reverse side of the Claim Form.