Universal Claim Form for a Compounded Medication

PHARMACIST / PHARMACY

Pharmacy Information	Pharmacist Name	Date
	Pharmacy NABP #	
Telephone	Pharmacist Signature	

PATIENT

Name	Telephone
Address	
City	State / Zip
Birthdate / Sex	Social Security #/Subscriber ID #
Patients Relationship to Cardholder	

CARDHOLDER

Name	Telephone
Address	
City	State / Zip
Birthdate / Sex	Social Security #/Subscriber ID #
Employer	Employer ID #
Group #	Plan #

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.

Patient Signature Date

I hereby authorize my Pharmacy (in either case, "Pharmacy") to execute on my behalf any assignment of benefits documents acquired to permit to 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.

Patient Signature Date

PRESCRIPTION

Prescription Medication Name	Price
Prescription #	Date Filled
Dosage Form	Strength
Active Ingredient (s)	Quantity Dispensed / Days Supply
	Prescriber's DEA #

Pharmacist Authorization

I hereby certify that the above compounded medication was ordered by the stated prescriber specifically for the stated patient. Because this prescription is compounded and not manufactured, an NDC number is not required for reimbursement.

Pharmacist Signature Date