Universal Claim Form for a Compounded Medication©

Recognized by the International Academy of Compounding Pharmacists

Pharmacist

Cardholder Information

Patient Information

Prescription Information

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

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 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.

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

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 reimburesement.

Pharmacist Signature Date

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 _____

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