



An Independent Licensee of the Blue Cross and Blue Shield Association

COMPOUNDED MEDICATION CLAIM FORM

Mail completed form and original receipts to: Blue Cross Blue Shield of Arizona
 Mail Stop A115
 P.O. Box 13466
 Phoenix, AZ 85002-3466

Instructions: Type or print clearly. All information in each section must be provided. **Incomplete forms will be returned, causing a delay in the claim review process.** Staple or tape pharmacy receipt the back of this form. A separate form must be completed for each patient and for each pharmacy patronized.

SECTION 1 – MEMBER INFORMATION

Member ID Number	Group Number or Plan Name	Name (Last, First, Middle Initial)	Date of Birth	Gender
Member Address (Street, City, State, Zip Code)			Member Phone Number	

SECTION 2– PHARMACY INFORMATION

Pharmacy NABP	Pharmacy NPI	Pharmacy Name
Pharmacy Address (Street, City, State, Zip Code)		Pharmacy Phone Number
Pharmacist's Name	Pharmacist's License Number	State ID Number

SECTION 3 – CLAIM INFORMATION

Rx Number	Date Prescribed	Date Filled	Refill	Quantity Dispensed	Days Supply
Prescriber Name		Prescriber NPI or DEA		Diagnosis Code	

SECTION 4 – COMPOUND INGREDIENTS

Ingredient NDC	Ingredient Quantity	Ingredient Cost	Ingredient NDC	Ingredient Quantity	Ingredient Cost
1.		\$	11.		\$
2.		\$	12.		\$
3.		\$	13.		\$
4.		\$	14.		\$
5.		\$	15.		\$
6.		\$	16.		\$
7.		\$	17.		\$
8.		\$	18.		\$
9.		\$	19.		\$
10.		\$	20.		\$

Other Coverage	Amount Charged	Other Coverage Amount	Patient Paid Amount	Net Billed
	\$	\$	\$	\$

For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

SECTION 5 – ATTESTATION Certifies that the information provided above is true, accurate, and complete.

Member Signature	Date	Dispensing Pharmacist Signature	Date
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