

NONCOMPOUND DRUG CLAIM

Instructions: Type or print clearly. Before completing this form, read the Noncompound Drug Claim Completion Instructions, F-13072A.

For questions, contact Provider Services at (800) 947-9627. For ForwardHealth members, return the completed form to: ForwardHealth, Claims and Adjustments, 6406 Bridge Road, Madison, WI 53784-0002.

For Wisconsin Chronic Disease Program members, return form to: ForwardHealth, P.O. Box 6410, Madison, WI 53716-0410.

SECTION I — PROVIDER INFORMATION

1. Name — Provider	2. National Provider Identifier
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3. Address — Provider (Street, City, State, ZIP+4 Code)

SECTION II — MEMBER INFORMATION

4. Member Identification Number	5. Name — Member (Last, First, Middle Initial)	6. Date of Birth — Member	7. Sex — Member	8. Copay Exempt
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SECTION III — CLAIM INFORMATION

9. Prescriber Number	10. Date Prescribed	11. Date Filled	12. Refill	13. NDC	14. Days Supply
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15. Quantity	16. Prescription Number	17. Drug Description
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18. Special Package Indicator	19. Dispense as Written	20. Place of Service	21. Diagnosis Code
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22. Level of Effort	23. Reason for Service	24. Professional Service	25. Result of Service
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26. Other Coverage Code	27. Charge \$	28. Other Coverage Amount \$	29. Patient Paid Amount \$	30. Net Billed \$
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31. Certification
 I certify the services and items for which reimbursement is claimed on this claim form were provided to the previously named member pursuant to the prescription of a licensed physician, podiatrist, or dentist. Charges on this claim form do not exceed my (our) usual and customary charge for the same services or items when provided to persons not entitled to receive benefits under ForwardHealth.

I understand that any payment made in satisfaction of this claim will be derived from federal and state funds and that any false claims, statements or documents, or concealment of a material fact may be subject to prosecution under applicable federal or state law.

32. SIGNATURE — Pharmacist or Dispensing Physician	33. Date Signed
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