DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-13073 (09/11)

STATE OF WISCONSIN
DHS 106.03(1), Wis. Admin. Code

COMPOUND DRUG CLAIM

Instructions: Type or print clearly. Before completing this form, read the Compound Drug Claim Completion Instructions, F-13073A. Return the completed form to: ForwardHealth, Claims and Adjustments, 6406 Bridge Road, Madison, WI 53784-0002.

SECTION I — PROVIDER INFORMATION

1. Name — Provider	2. National Provider Identifier
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

SECTION III — CLAIM INFORMATION

9. Prescriber Number	10. Date Prescribed	11. Date Filled	12. Refill	13. Days' Supply	14. Quantity Dispensed

15. Prescription Number	16. Place of Service	17. Diagnosis Code	18. Level of Effort

SECTION IV — COMPOUND INGREDIENTS

	Ingredient NDC	Ingredient Quantity	Ingredient Cost		Ingredient NDC	Ingredient Quantity	Ingredient Cost
1.			$	14.			$
2.			$	15.			$
3.			$	16.			$
4.			$	17.			$
5.			$	18.			$
6.			$	19.			$
7.			$	20.			$
8.			$	21.			$
9.			$	22.			$
10.			$	23.			$
11.			$	24.			$
12.			$	25.			$
13.			$				

19. Other Coverage Code	20. Charge	21. Other Coverage Amount	22. Patient Paid Amount	23. Net Billed
	$	$	$	$

24. Certification
I certify that 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.

25. **SIGNATURE** — Pharmacist or Dispensing Physician	26. Date Signed

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