

**FORWARDHEALTH
NONCOMPOUND DRUG CLAIM**

INSTRUCTIONS: Type or print clearly. Before completing this form, refer to the Noncompound Drug Claim Instructions, F-13072A. For questions, contact Provider Services at 800-947-9627.

For Medicaid, BadgerCare Plus, and SeniorCare members, return the completed form to ForwardHealth, Claims and Adjustments, 313 Blettner Boulevard, Madison, WI 53784.

For Wisconsin Chronic Disease Program (WCDP) members, return the completed form to WCDP, P.O. Box 6410, Madison, WI 53716-0410.

For Wisconsin HIV Drug Assistance Program (HDAP) members, return the completed form to ForwardHealth, HDAP Claims and Adjustments, P.O. Box 8758, Madison, WI 53708.

SECTION I – PROVIDER INFORMATION

1. Name – Billing Provider	2. National Provider Identifier (NPI) – Billing Provider
3. Address – Billing Provider (Street, City, State, Zip+4 Code)	

SECTION II – MEMBER INFORMATION

4. Member ID Number	5. Name – Member (Last, First, Middle Initial)	
6. Date of Birth – Member	7. Gender – Member	8. Copay Exempt

SECTION III – CLAIM INFORMATION

9. NPI – Prescriber	10. Date Prescribed	11. Date Filled		
12. Refill	13. National Drug Code	14. Days' Supply		
15. Quantity Dispensed		16. Prescription Number		
17. Drug Description		18. Special Package Indicator		
19. Dispense as Written		20. Place of Service		
21. Diagnosis Code		22. Submission Clarification Code		
23. Other Coverage Code	24. Total Charges \$	25. Other Coverage Amount \$	26. Member's Out-of-Pocket Costs \$	27. Net Billed Amount \$



28. Provider 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 a valid prescription. Charges on this claim form do not exceed the usual and customary charges 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.

29. SIGNATURE – Pharmacist or Dispensing Physician	30. Date Signed
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