DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-13073 (04/2017)

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

FORWARDHEALTH
COMPOUND DRUG CLAIM

Instructions: Type or print clearly. Before completing this form, read the Compound Drug Claim Completion Instructions, F-13073A. For questions, contact Provider Services at 800-947-9627.

Return the completed form to ForwardHealth, Claims and Adjustments, 313 Blettner Boulevard, Madison, WI 53784.

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 Identification 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. Days' Supply
14. Quantity Dispensed	15. Prescription Number	16. Place of Service	17. Diagnosis Code	18. Submission Clarification Code

SECTION IV – COMPOUND INGREDIENTS

	Ingredient National Drug Code (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. Total Charges	21. Other Coverage Amount	22. Member's Out-of-Pocket Costs	23. Net Billed Amount
	$	$	$	$

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 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.

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

Reset Form