

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, 313 Blettner Boulevard, Madison, WI 53784.

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
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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

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