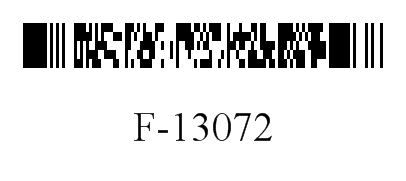
**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**



Division of Medicaid Services Wis. Admin. Code § DHS 106.03(1)

F-13072 (04/2017)

**FORWARDHEALTH**

**NONCOMPOUND DRUG CLAIM**

**Instructions:** Type or print clearly. Before completing this form, refer to the Noncompound Drug Claim Completion 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 AIDS Drug Assistance Program (ADAP) members, return the completed form to ForwardHealth, ADAP Claims and Adjustments, P.O. Box 8758, Madison, WI 53708.

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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. 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 | |