

MEDICARE SUPPLEMENT

Compounded Medication Claim Form



An Independent Licensee of the Blue Cross Blue Shield Association

Mail completed form and original receipts to: Blue Cross Blue Shield of Arizona
Mail Stop A115
P.O. Box 13466
Phoenix, AZ 85002-3466

Instructions: Type or print clearly. All information in each section must be provided. **Incomplete forms will be returned, causing a delay in the claim review process.** Staple or tape pharmacy receipt (label) to the back of this form. A separate form must be completed for each member and for each pharmacy patronized. For non-compounded medications, please use the **Prescription Medication Reimbursement Form** to submit your claim.

Section 1 – Member Information

Member's ID Number	Group/Employer or Plan Name	Group ID Number
Member's Name (Last, First, Middle Initial)	Member's Date of Birth	Member's Gender ☐ Male ☐ Female
Member's Address (Street, City, State, ZIP)		

Section 2 – Member Representative Information

Member Representative's Name (Last, First, Middle Initial)	Member's Date of Birth	Member's Gender ☐ Male ☐ Female	Relationship to Member
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Section 3 – Pharmacy Information

Pharmacy NABP	Pharmacy NPI	Pharmacy Name
Pharmacy Address (Street, City, State, ZIP)		Pharmacy Phone Number
Pharmacist's Name	Pharmacist's License Number	State ID Number

Section 4 – Prescriber Information

Prescribing Physician's Name	Physician's NPI or DEA Number	Physician's Phone Number
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Section 5 – Claim Information

Rx Number	Date Prescribed	Date Filled	Refill	Quantity Dispensed	Day's Supply	Diagnosis Code
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Section 6 – Compound Ingredients

	Ingredient NDC	Quantity	Cost		Ingredient NDC	Quantity	Cost
1.			\$	11.			\$
2.			\$	12.			\$
3.			\$	13.			\$
4.			\$	14.			\$
5.			\$	15.			\$
6.			\$	16.			\$
7.			\$	17.			\$
8.			\$	18.			\$
9.			\$	19.			\$
10.			\$	20.			\$
Other Coverage \$	Amount Charged \$	Other Coverage Amount \$		Patient Paid Amount \$	Net Billed Amount \$		

For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Section 7 – Attestation

Certifies that the information provided is true, accurate, and complete.

Member's Signature	Date	Dispensing Pharmacist's Signature	Date
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