



# Pharmacy Compound Claim Form

## Step 1: Complete the Patient Information

- Each section must be filled out completely
- A separate form must be used for each patient

Patient Information			
Last Name:		First Name:	
ID #:	Date of Birth:	Phone #:	
Address:			
City:	State:	Zip:	
Relationship to Cardholder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:			
Other Coverage Information			
Does the patient have other prescription coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, is this plan primary or secondary? <input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Other			
Note: If this plan is secondary, an explanation of benefits from the primary plan is required			

## Step 2: Complete Compound Prescription Information

- List the NDC and name of each ingredient used in the compound, all ingredients must be submitted
- Express the metric quantity as number of tablets, grams, or milliliters used for each NDC
- Indicate the total day supply of the compound
- List the cost for each ingredient and total amount paid by the patient

Prescription Information					
Date Filled:			Pharmacy Name:		
Prescriber Name:			Pharmacy NPI:		
Rx #	NDC #	Ingredient Name	Metric Quantity	Day Supply	Ingredient Cost
Total Amount Paid By Patient:					

Prescription Information					
Date Filled:			Pharmacy Name:		
Prescriber Name:			Pharmacy NPI:		
Rx#	NDC #	Ingredient Name	Metric Quantity	Day Supply	Ingredient Cost
Total Amount Paid By Patient:					



### **Step 3: Send Form & Pharmacy Receipts**

- Fax forms and receipts to 503-346-8326 or mail the completed form and pharmacy receipts to:  
OHSU PBM Services  
8300 Creekside Place, Suite 100  
Beaverton, OR 97008
- Keep a copy of all documents sent for your own records

### **Processing Information:**

- Allow up to 30 days for processing of your reimbursement requests
- Non-compound prescription reimbursement requests should be submitted via the Member Reimbursement Request Form
- Reimbursement of prescriptions is not guaranteed and is subject to plan provisions
- For questions regarding this form or reimbursement processing, please contact 1-833-247-6880

### **Signature Required**

I certify that the information on this form is true and accurate. I certify that the patient on this form has received the prescriptions and is covered by this plan.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Relationship to Patient:**    Self    Spouse    Parent/Legal Guardian    Pharmacy Representative