An Independent Licensee of the Blue Cross and Blue Shield Association

Compounded Medication Claim Form

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 patient and for each pharmacy patronized. For non-compounded medications, please use the **Prescription Medication Reimbursement Form** to submit your claim.

Section 1 - Cardholder Information

Cardholder's ID Number	Group/Employer or Plan Name	Group ID Number

Cardholder's Name (Last, First, Middle Initial)	Cardholder's Date of Birth	Cardholder's Gender	Cardholder's Phone Number
		☐ Male ☐ Female	

Cardholder's Address (Street, City, State, Zip)

Section 2 - Patient Information

Patient's Name (Last, First, Middle Initial)	Patient's Date of Birth	Patient's Gender	Relationship to Cardholder
		☐ Male ☐ Female	☐ Self ☐ Spouse ☐ Dependent

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

Section 5 - Claim Information

Rx Number	Date Prescribed	Date Filled	Refill	Quantity Dispensed	Day's Supply	Diagnosis Code

Section 6 - Compounded 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 above is true, accurate, and complete.

Member's Signature	Date	Dispensing Pharmacist's Signature	Date