

COMPOUNDED MEDICATION CLAIM FORM



Use this form for compound drugs that were not submitted electronically.

The following criteria must be met:

Compound medications must have at least 2 ingredients, and at least 1 ingredient must be a Federal legend drug.

- All active ingredients must be covered as part of the Colorado Access formulary, and the NDC for each ingredient must be submitted.
- **For compounds requiring Prior Authorization (PA), the physician who prescribed the compound must submit the PA form to Colorado Access. Compounds that require PA are:**

√ Compound prescriptions costing over \$200.00
AND/OR

√ Compound prescriptions containing individual ingredients which, according to the Colorado Access Formulary, require prior authorization for coverage.

Please note: The cost of unit dose packaging is not covered. Compounds containing any non-covered ingredients will be denied. Claim submission is not a guarantee of payment. Reimbursement is subject to plan benefits. Please submit itemized receipts.

MEMBER INFORMATION

Cardholder Name:	Cardholder #:
Group # (RxGrp):	Group Name (RxPCN):
Patient's Gender: __ Female __ Male	Patient Date Of Birth:
Mail Reimbursement to:	
Does Patient have other drug coverage: __Yes __No If yes, and other insurance <i>is</i> Medicare, attach a copy of the Medicare Explanation of Benefits (MEOB). If yes, and other insurance <i>is not</i> Medicare, include denial notification from the primary insurance carrier or pharmacy printout.	

CLAIM INFORMATION

Pharmacy Name		Pharmacy NPI #	Rx Number
Original Date of Prescription	Date of Fill	Final Form of Compound (cream, suppository, suspension, etc.)	
Total Volume (grams, ml, each, etc.)		Compound Preparation Time	Days Supply
Physician Name	Physician NPI #	Directions	Diagnosis

COMPOUND INGREDIENTS

	INGREDIENT NAME	INGREDIENT NDC	METRIC DECIMAL QUANTITY	AWP
1				
2				
3				
4				
			Total Ingredient Cost	
<input type="checkbox"/> Pay Pharmacy			Member Copay	
<input type="checkbox"/> Pay Subscriber / Member				

PLEASE SIGN AND DATE HERE: I CERTIFY THE ABOVE INFORMATION IS CORRECT, AND THE PRESCRIPTIONS FOR WHICH REIMBURSEMENT IS REQUESTED ON THIS CLAIM FORM WERE PROVIDED TO THE ABOVE MEMBER PURSUANT TO THE PRESCRIPTION OF A LICENSED PHYSICIAN, PODIATRIST, DENTIST, NURSE PRACTITIONER OR PHYSICIAN ASSISTANT.

SIGNATURE: _____ DATE SIGNED: _____

**MAIL TO: COLORADO ACCESS
GRIEVANCES AND CLINICAL APPEALS
PO BOX 17950
DENVER, CO 80217-0950
FAX: 303-755-4148**