Compounded Medication Claim Form

For compound medication claim reimbursement, complete and mail this form to Centene Pharmacy Services, 7625 N Palm Ave, Suite 107 Fresno, CA. 93711. Forms can also be faxed to (844) 678-5767 or email to claimsprocessing@centene.com. **Incomplete forms will delay processing**. Centene Pharmacy Services' customer service desk can be reached at (800) 413-7721. For non-compounded medications, please use the 'Prescription Claim Reimbursement Form' to submit your claim.

To be completed by insured. Please PRINT clearly.

I. CARDHOLDER INFORMATION		
Cardholder Name:		Cardholder ID #:
Cardholder Address:		Group #:
Birth Date: / /	Phone:	Group/Employer or Plan Name:
Cardholder Gender: Male Female		
II. PATIENT INFORMATION		
Patient Name:		Patient Birth Date: / /
Patient Gender: Male Female		Relationship to Cardholder: Self Spouse Dependent
III. PHARMACY INFORMATION		
Pharmacy Name:		Pharmacy Address:
Pharmacy NPI:	Pharmacy NAPB:	Pharmacy Phone #:
Pharmacist Name:		Pharmacist License #:
State ID #:		
IV. PRESCRIBER INFORMATION		
Prescribing Physician's Name:	Physician's NPI or DEA #:	Physician's Phone #:

(Continued on back)

I. CLAIM INFORMATION		
RX Number:	Date Prescribed:	Date Filled:
Refill:	Date Filled:	Quantity Dispensed:

This section must be completed by you or your dispensing pharmacist. One prescription label should be attached for each prescription. Also, include a copy of your pharmacy receipt with this form.

II. 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	Over Coverage Amount	Patient Paid Amount	Net Billed Amount
$	$	$	$	$

Important! A signature is required.

Please sign and date here: I certify that the above information is correct and the prescriptions listed above are for myself or eligible members of my family who have received the medication described above, and I authorize release of all information contained on this claim form to Centene Pharmacy Services and my plan sponsor.

Signature: _____ Date signed:_____