Compounded Medication Claim Form

For compound medication claim reimbursement, complete and mail this form to 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**. 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's License #:
State ID #:		

IV. PRESCRIBER INFORMATION

Prescribing Physician's Name:	Physician's NPI or DEA #:	Physician's Phone #:

V. 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.

VI. 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 Pharmacy Services and my plan sponsor.

Signature:_____ **Date signed:** _____