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: ☐ Self ☐ Spouse ☐ Child ☐ Other:		

Other Coverage Information
Does the patient have other prescription coverage? ☐ Yes ☐ No
If yes, is this plan primary or secondary? ☐ Primary ☐ Secondary ☐ 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