

PLEASE PRINT CLEARLY				Indiana Family and Social Services Administration						
Indiana Health Coverage Programs COMPOUNDED PRESCRIPTION CLAIM FORM										
MEMBER NAME: LAST, FIRST 1			RID NO. 2		PRESCRIBER NPI 3	EMERGENCY 4	PREG 5	PATIENT LOCATION CODE 6		
DAW CODE 7		REFILL NUMBER 8	PRESCRIPTION NUMBER 9	DATE PRESCRIBED 10		DATE DISPENSED 11	TOTAL QUANTITY DISPENSED 12	DAYS SUPPLY 13		
USUAL & CUSTOMARY CHARGE 14		ROUTE OF ADMINISTRATION CODE 15	SUBMISSION CLARIFICATION CODE 16	OTHER COVERAGE CODE 17	TPL AMOUNT PAID 18	OTHER AMOUNT CLAIMED SUBMITTED 19	GROSS AMOUNT DUE 20			
LINE NUMBER	21	NDC NUMBER		22			DESCRIPTION OF INGREDIENT		23	INGREDIENT QUANTITY
1										
2										
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12										

BILLING PROVIDER'S NAME AND ADDRESS 24	This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any falsification of claims, statements or documents, or concealment of material fact may be prosecuted under applicable Federal or State laws. I, the undersigned, being aware of restricted funds in the Medicaid Program, agree to accept as full payment for services enumerated on this claim form, for this Medicaid patient, the allowance determined by the Department or its designee. I further certify that no supplemental charges have been or will be billed to the patient. I further recognize that any difference of opinion concerning the charges and/or allowance for this claim shall be adjudicated as specified in the Provider Manual. Signature of Provider or Representative <input type="checkbox"/> 27
BILLING PROVIDER NPI 25	
PROVIDER TYPE <input type="checkbox"/> PHARMACY <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> DENTIST <input type="checkbox"/> OTHER 26	
Date Filed 28	

MAIL COMPLETED CLAIM FORM TO:
HP Pharmacy Claims
P.O. Box 7268
Indianapolis, IN 46207-7268
Effective: November 3, 2009