

PLEASE PRINT CLEARLY				Indiana Family and Social Services Administration						
<b>Indiana Health Coverage Programs</b> <b>COMPOUNDED PRESCRIPTION CLAIM FORM</b>										
MEMBER NAME: LAST, FIRST 1			RID NO. 2		PRESCRIBER NPI 3	EMERGENCY 4	PREG 5	PATIENT RESIDENCE 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	OTHER PAYER AMOUNT PAID 18	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT 19				
LINE NUMBER	20	NDC NUMBER	21				DESCRIPTION OF INGREDIENT		22	INGREDIENT QUANTITY
1										
2										
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BILLING PROVIDER'S NAME AND ADDRESS 23		<p>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.</p> <p>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.</p> <p>Signature of Provider or Representative <input type="checkbox"/> 26</p> <p>Date Filed 27</p>
BILLING PROVIDER NPI 24		
PROVIDER TYPE <input type="checkbox"/> PHARMACY <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> DENTIST <input type="checkbox"/> OTHER 25		

MAIL COMPLETED CLAIM FORM TO:

**HP Pharmacy Claims**  
**P.O. Box 7268**  
**Indianapolis, IN 46207-7268**

Effective: January 1, 2012