Compound Prescription Drug Claim Form

PLEASE PRINT CLEARLY

Provider Number 1	Loc	Telephone Number 2						
PATIENT'S NAME: LAST, FIRST 3		CLIENT NO. 4	PRESCRIBER'S I.D. NUMBER 5	EMERG 6	PREG 7	N.H. PAT 8	BRAND 9	REFILL 10

PRESCRIPTION NUMBER 11	DATE PRESCRIBED 12	DATE DISPENSED 13	LOCAL USE ONLY 14	DAYS 15	CHARGE 16	3RD PARTY PAID 17

LINE NUMBER	NDC NUMBER 21	DESCRIPTION OF INGREDIENT 22	QUANTITY 23
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			

Provider's Name and Address ?
18

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 law.
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
19

Date Billed
20

MAIL COMPLETED CLAIM FORM TO:
DXC Technology
P.O. Box 18650
Oklahoma City, OK 73154

Compound Prescription Drug Claim Form

Required Data Elements

11. Prescription Number – 7 characters

12. Date Prescribed – must be on or before receipt date, cannot be a future date

13. Date Dispensed – must be on or before receipt date, cannot be a future date

15. Days Supply – up to 3 characters

16. Charge – numeric, up to nine digits

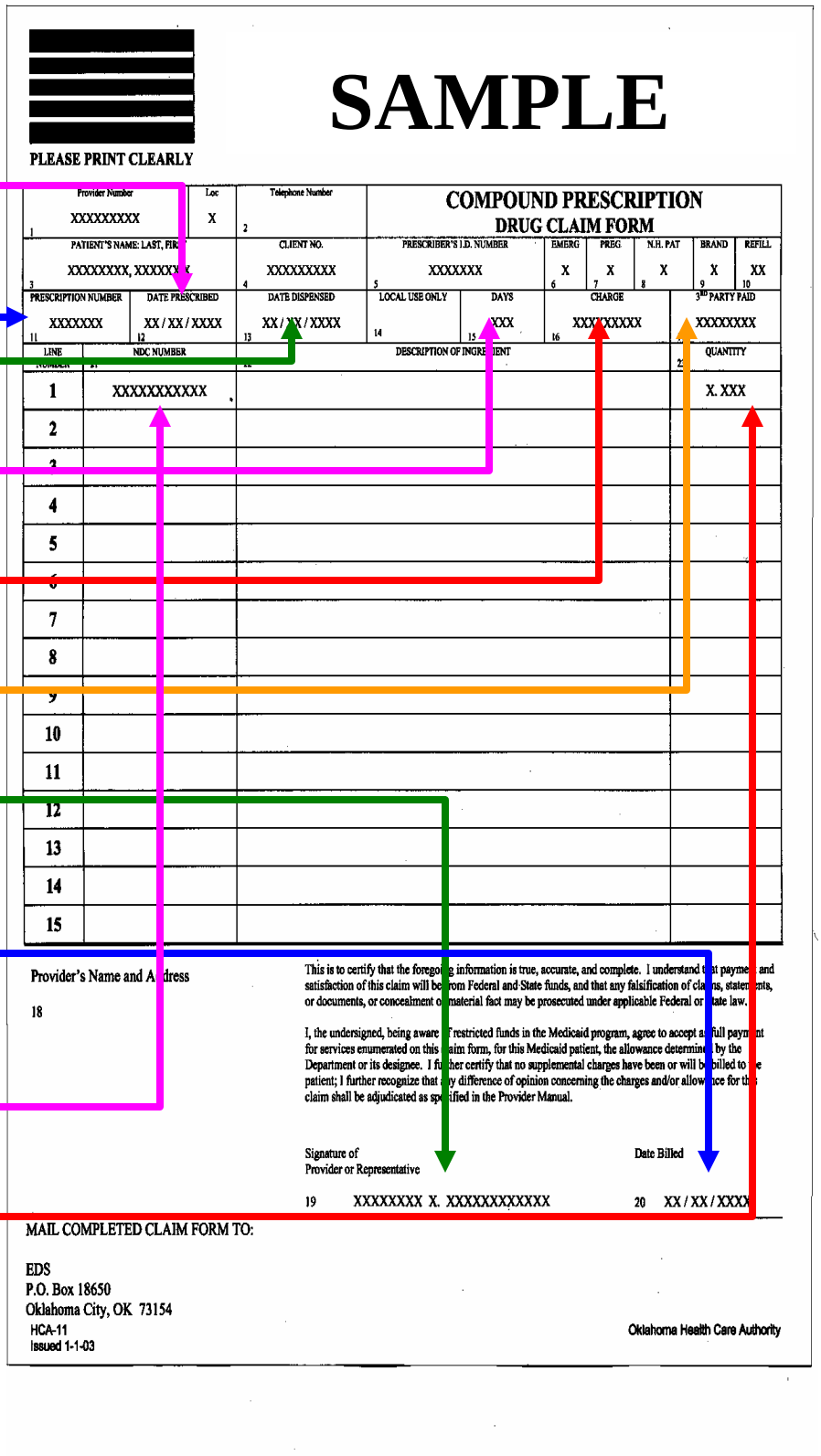
17. TPL Paid – numeric, up to eight digits

19. Signature of Provider or Representative

20. Date Billed/Date of Claim Submission – must be on or before receipt date, no future date

21. NDC Number – numeric, 11 digits

23. Metric Unit Quantity – Example: 9999999.999



SAMPLE

PLEASE PRINT CLEARLY

COMPOUND PRESCRIPTION DRUG CLAIM FORM

Provider Number	Loc	Telephone Number
XXXXXXXXX	X	

PATIENT'S NAME: LAST, FIR	CLIENT NO.	PRESCRIBER'S I.D. NUMBER	EMERG	PREG	N.H. PAT	BRAND	REFILL
XXXXXXXX, XXXXX	XXXXXXXXX	XXXXXXX	X	X	X	X	XX

PRESCRIPTION NUMBER	DATE PRESCRIBED	DATE DISPENSED	LOCAL USE ONLY	DAYS	CHARGE	3RD PARTY PAID
XXXXXXX	XX / XX / XXXX	XX / XX / XXXX		XXX	XXXXXXXXX	XXXXXXXX

LINE NUMBER	NDC NUMBER	DESCRIPTION OF INGREDIENT	QUANTITY
1	XXXXXXXXXX		X. XXX
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			

Provider's Name and Address

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Signature of Provider or Representative

19 XXXXXXXX X. XXXXXXXXXXXX

Date Billed

20 XX / XX / XXXX

MAIL COMPLETED CLAIM FORM TO:

EDS
P.O. Box 18650
Oklahoma City, OK 73154

HCA-11
Issued 1-1-03

Oklahoma Health Care Authority

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