Prescription Drug Claim Form

Compound Claim

Part 1: Member Information

1. Complete ALL information. Your ID Number can be located on your member ID card.
2. Submit claims within the filing period specified by your Benefit plan. For questions about your filing period please review your Member handbook or call the Customer Care number on your member ID card.
3. Please submit a separate form for each patient for which you purchased medications.
4. Reimbursement will be made directly to the CARDHOLDER unless otherwise noted.

First Name	Last Name	MI
Telephone Number ( )	Date of Birth	Gender (Circle One) Male Female
ID Number	Subscriber's Employer (PCN)	
Mailing Address		
City	State	ZIP Code
Member Signature		Date Signed

Part 2: Pharmacy Information

1. Complete ALL information.
2. Please submit a separate form for each pharmacy from which you purchased medications.

Name		
Street Address		
City	State	ZIP Code
Pharmacy National Provider Number		Telephone Number ( )
Pharmacist Signature		

For Reimbursement of Compound Drug Preparation, see the table below.
Please indicate the time spent preparing the compound drug in the Receipt Information on page 2.

Time	Reimbursement
1 – 5 minutes	$10.00
6 – 15 minutes	$15.00
16 – 30 minutes	$20.00
31+ minutes	$25.00

Part 3: Receipt Information

1. Include original pharmacy receipt(s) or pharmacy printout(s); Cash Register Receipt(s) without pharmacy detail will not be accepted. Tape original pharmacy receipt(s) to additional page and submit with claim form. *Please* DO NOT staple.
    a. Compound medications must have at least 2 ingredients, and at least 1 ingredient must be a Federal legend drug.
    b. All active ingredients must be covered as part of your formulary and all script information must be submitted.
2. Receipt(s) must contain the information outlined under Part 3. If your receipt(s) are missing any of this information, please have your pharmacist fill in the missing information.
3. An incomplete form may be denied, delayed or returned.
4. Receipts will not be returned, remember to keep a copy of the completed claim form and receipt(s) for your records.

Rx Written Date	Date Rx Filled	Diagnosis Code and Description
Rx Number	Final Form of Compound (cream, patches, suppository, suspension, etc.)	
Day Supply	Total Volume (Grams, ml, etc.)	
Prescribing Physician First/Last Name		Prescribing Physician NPI
Original Cost of Rx		Member Paid Amount

Compound Ingredients

	Ingredient Name	Ingredient NDC	Metric Decimal Quantity	AWP/WAC
1				
2				
3				
4				
			Total Ingredient Cost	
			Preparation Time	
			Member Copay	

Reimburse (Circle One)	
Pharmacy	Member

Mail this form along with receipts to:
Navitus Health Solutions, LLC
P.O. Box 999
Appleton, WI 54912-0999
OR
Fax this form along with receipt(s) to:
(920)735-5315 / Toll Free (855)668-8550