



**STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY
Compound Prescription Drug Claim**

PLEASE PRINT CLEARLY

1 ProviderNumber		Loc	Telephone Number								
3 PATIENT'S NAME: LAST, FIRST			2 CLIENT NO.	PRESCRIBER'S I.D. NUMBER		EMERG	PREG	N.H. PAT	BRAND	REFILL	
3 PRESCRIPTION NUMBER		4 DATE PRESCRIBED		5 DATE DISPENSED		6 LOCAL USE ONLY		7 DAYS		8 CHARGE	9 3 RD PARTY PAID
11 LINE NUMBER	21 NDC NUMBER		22 DESCRIPTION OF INGREDIENT					17 QUANTITY			
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:

EDS
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

Provider Number XXXXXXXXXX		Loc X	Telephone Number		COMPOUND PRESCRIPTION DRUG CLAIM FORM					
PATIENT'S NAME: LAST, FIRST, MIDDLE XXXXXXXX, XXXXXXX, XXXXXXX			CLIENT NO. XXXXXXXXXX	PRESCRIBER'S I.D. NUMBER XXXXXXX		EMERG X	PREG X	N.H. PAT X	BRAND X	REFILL XX
PRESCRIPTION NUMBER XXXXXXXX	DATE PRESCRIBED XX / XX / XXXX	DATE DISPENSED XX / XX / XXXX	LOCAL USE ONLY	DAYS XXX	CHARGE XXXXXXXXXX		3 RD PARTY PAID XXXXXXXXXX			
LINE 1	NDC NUMBER XXXXXXXXXXXX	DESCRIPTION OF INGREDIENT						QUANTITY X.XXX		
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										

18. Provider's Name and Address

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 the restrictions in the Medicaid program, agree to accept a 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: _____ Date Billed: _____

19. XXXXXXXX X. XXXXXXXXXXXXX 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