CHANGE HEALTHCARE™

Return to: Change Healthcare
45 Commerce Drive, PO Box 1090
Augusta, Maine 04332-1090
Fax Number: 1-800-408-1088

PAYMENT REQUEST FORM
MAINE COMPOUND CLAIM - NCPDP vD.0

Patient Name	Cardholder ID	Pharmacy Name	NABP

Street Address	City	Plan Name	Patient DOB	Gender	Pharmacy Address	NPI

Comments:	Other Coverage Code			Total Billed

Rx Number	Ref #	Prescriber DEA/BNDD #	Prescriber Name	Date Prescribed	Date Filled	Quantity	Days' Supply

PA #	MN	Drug Name, Strength, Dosage, Mfg.	NDC	PDP Copay	Submission Clarification Code

Coordination of Benefits (COB) – Other Payer Information

	Other Payer ID	ID Qual.	Other Payer Date	Other Payer Rejects	Other Payer-Patient Responsibility Qualifier/Amounts					
					Qual	Amt	Qual	Amt	Qual	Amt
1										
2					Qual	Amt	Qual	Amt	Qual	Amt

COMPOUND INFORMATION

	Product ID	Product Name	ID Qual	Ingredient Quantity	Ingredient Drug Cost	Basis of Cost
1						
2						
3						
4						
5						

Final Dispensed Product (select one)				Special Procedures Used				Prep Time
	IV bag:		Cream/ointment/gel/lotion oral liquid		Sterile Prep Area		Healing Product	
	Syringe:		Capsule/lozenge/suppository/troche/tablet/powder		Sterile Prep Area		Healing Product	

Provider Signature		Date Signed			

Updated: 12/05/2011