COMPOUNDED MEDICATION CLAIM FORM

USE THIS FORM FOR COMPOUND DRUGS THAT WERE NOT SUBMITTED ELECTRONICALLY.

The following criteria must be met:

1. Compound medications must have at least two ingredients, and at least one ingredient must be a federal legend drug.
2. All active ingredients must be covered as part of the formulary, and the NDC for each ingredient must be submitted.
3. For compounds requiring prior authorization (PA), the physician who prescribed the compound must submit the PA form. Compounds that require PA are:
   - Compound prescriptions that cost more than $200.00 AND/OR
   - Compound prescriptions that contain individual ingredients which, according to the formulary, require prior authorization for coverage.

PLEASE NOTE: The cost of unit dose packaging is not covered. Compounds containing any non-covered ingredients will be denied. Claim submission is not a guarantee of payment. Reimbursement is subject to plan benefits. Please submit itemized receipts.

MEMBER INFORMATION

Cardholder name:	Cardholder phone:	
Cardholder address:		
City:	State:	Zip:
Group number (RxGrp):	Group name (RxPCN):	
Patient date of birth:	Gender: ☐ Male ☐ Female	
Mail check to:		

CLAIM INFORMATION

Pharmacy name:	Pharmacy NPI #:	
Rx #:	Original date of Rx:	Date of fill:
Final form of compound (cream, suppository, suspension, etc.):		
Total volume (grams, ml, etc.):	Compound prep time:	Days supply:
Physician name:	Physician NPI #:	
Directions:	Diagnosis:	

COMPOUND INGEDIENTS

	Ingredient name	Ingredient NDC			Metric decimal quantity	Average wholesale price (AWP)
1						
2						
3						
4						
		Pay pharmacy			Total ingredient cost	
		Pay subscriber/member			Member copay	

PLEASE SIGN AND DATE HERE: I certify the above information is correct, and the prescriptions for which reimbursement is requested on this claim form were provided to the above member pursuant to the prescription of a licensed physician, podiatrist, dentist, nurse practitioner, or physician assistant.

Provider Signature Date

FAX: 720-744-5127
OR MAIL: COA/AHC Grievances and Clinical Appeals Department, PO Box 17950, Denver, CO 80217-9691

Colorado ACCESS coaccess.com 1-800-511-5010

Access Health COLORADO accesshealthco.com 1-855-325-9426