

STATEMENT FOR COMPOUND PRESCRIPTION

Instructions for completing form on the reverse side.

DO NOT
 WRITE IN
 SPACE

Pharmacy name & address CVC Provider no. / NPI Federal Tax ID	Claimant's soc. sec. no. (for ID only) _____ Claim no. _____ Claimant's name (last, first, middle) print or type _____ Claimant's mailing address _____ City _____ State _____ ZIP _____ Pharmacy billing date (mm/dd/yyyy) _____
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Is this a request to reimburse the claimant? YES NO
 Is this a private insurance co-payment? YES NO

PRESCRIPTION DETAIL Print Or Type All Information

DX Code (ICD-9)	S/B	Date of injury	Date Rx written	Prescribing provider's name	Drug cost	\$
Prescription no.	Date filled	Refill <input type="checkbox"/> YES <input type="checkbox"/> NO	Quantity Doses: Grams: Milliliters:	Dispensing fee	\$	
Compound drug code 00990000000	Total No. of ingredients	Dispense as written product selection code (daw) (0, 1 or 6)	Compounding time	Professional fee	\$	
Prescription filled for:	<input type="checkbox"/> Antibiotic IV therapy <input type="checkbox"/> Total parental nutrition	<input type="checkbox"/> Pain cocktail	<input type="checkbox"/> Topical preparation	Prescription total	\$	

COMPOUND ITEMIZATION

ATTACH ADDITIONAL ITEMIZATION OF OTHER
 INGREDIENTS IF MORE THAN 10 WERE USED

NDC/UPC	Name	Strength	Quantity (X)	Drug cost/unit	(=) Drug cost
1.				/	\$
2.				/	\$
3.				/	\$
4.				/	\$
5.				/	\$
6.				/	\$
7.				/	\$
8.				/	\$
9.				/	\$
10.				/	\$

Reimburse the claimant: Pharmacist's signature is required.

The claimant has paid for the above services and prescription(s).

 Pharmacist's Signature X _____

When you submit this bill, you are certifying that the prescription information is correct.

CVC must receive this statement within 12 months of the date of service, claim allowance or primary insurance payment decision.

* If primary insurance has made payment, bill only the total that is patient responsibility.



Instructions for completing Statement for Compound Prescription form

Types of Insurance

CRIME VICTIMS

Claim numbers are six digits beginning with a "V", or five digits preceded by a "VA, VB, VC, VH, VJ, VK or VL."

Send bills for Crime Victims claims to:

Department of Labor and Industries
Crime Victims Compensation
PO Box 44520
Olympia WA 98504-4520

STATE FUND INDUSTRIAL INSURANCE

Claim numbers are six digits, beginning with a "B, C, F, G, H, J, K, L, M, N, P, X, Y or double alpha followed by 5 digits."

Send bills for Industrial Insurance claims to:

Department of Labor and Industries
PO Box 44269
Olympia WA 98504-4269

SELF-INSURANCE

Claim numbers are six digits beginning with an "S, T or W."

Department of Energy claims are now Self-Insured.

Claim numbers are seven digits beginning with "7, 8 or 9."

Send bills to the employer or their service company.

Pharmacy address changes

PHARMACY NAME AND ADDRESS: If any of this information changes, call 1-800-762-3716 immediately.
(Simply indicating a new address on the bill will not change CVC's record of address for the provider.)

Prescription Information

CVC PROVIDER NUMBER / NPI: The specific Provider number or NPI issued to the pharmacy.

FEDERAL TAX ID #: IRS (Internal Revenue Service) Federal tax identification number.

REIMBURSE INJURED WORKER: Place "X" in applicable box.

S/B (SIDE OF BODY): Designate "L" (left), "R" (right) side of body or "B" (bilateral), to indicate location of injury.

DATE OF INJURY: This is important and must be included. One claimant may have several claims, so it is vital the proper claim be identified and charged for services provided.

DRUG COST: Total charge for the filled prescription.

QUANTITY: The total units of medication prescribed. Use the (NCPDP) billing unit standard format, e.g., "each", "ml" or "gm".

DISPENSING FEE: The fee for services provided by the pharmacist.

TOTAL NUMBER OF INGREDIENTS: The number of NDC/UPC ingredients used in the prescription.

DISPENSED AS WRITTEN PRODUCT SELECTION CODE: Code indicating whether or not the prescriber's instructions regarding generic substitution were followed.

Valid values are:

- 0 = No product selection mandated;
- 1 = Substitution not allowed by prescriber;
- 6 = Override for emergency supply - This value is used only by in-state pharmacies when dispensing an emergency supply of a non-preferred drug prescribed by a non-endorsing practitioner.

COMPOUNDING TIME: Time required to combine the ingredients in the prescription.

PROFESSIONAL FEE: Fee for compounding time.

PRESCRIPTION FILLED FOR: Place an "X" in the applicable box.

TOTAL PRESCRIPTION COSTS: Total charge for the filled prescription. (Drug cost + professional fee + applicable tax).

COMPOUND ITEMIZATION: Detail of the ingredients used in the prescription.

REIMBURSE THE CLAIMANT: Signature of pharmacist who supplied the prescription is required.