Universal Claim Form for a Compounded Medication
Recognized by the International Academy of Compounding Pharmacists

Leesburg Pharmacy
36 C Catoctin Circle
Leesburg, VA 20175

Name Telephone

Address

City State Zip

Birth Date Sex (M/F) Soc Security/ID No.

Patient's Relationship to Cardholder

Cardholder Information

Name Telephone

Address

City State Zip

Birth Date Sex (M/F) Soc Security/ID No.

Employer Employer ID.

Group No. Plan No.

Patient Authorization

I hereby authorize release of information health care providers, institutions, and/or payers that may pertain to my illness and/or treatment received. I certify that the information that I have reported with regard to my insurance coverage is correct, and I have received the pharmacist care/services rendered.

Patient Signature Date

Prescription Information

Medication Name		Price
Prescription Number	Days Supply	Date Filled
Dosage Form		Strength
Active ingredients		Quantity Dispensed
Prescriber's Name		DEA#

Pharmacist Authorization

I hereby certify that the above compounded medication was ordered by the stated prescriber specifically for the stated patient. This medication is not commercially available in this formulation or dosage form. The compounding was done using the highest possible standards, pure chemicals or drugs and contemporary technology. Because this prescription medication is compounded and not manufactured, an NDC member is not required for reimbursement

Pharmacist Signature Date