18.2 Universal Claim Form:

(PERF)

TYPE OR PRINT ALL INFORMATION NEATLY AND COMPLETELY IN APPROPRIATE SPACES

CARDHOLDER I.D. _____ GROUP I.D. _____

CARDHOLDER NAME _____ PLAN NAME _____

PATIENT NAME _____ OTHER COVERAGE CODE (1) _____ PERSON CODE (2) _____

PATIENT DATE OF BIRTH MM DD CCYY _____ PATIENT (3) GENDER CODE _____ PATIENT (4) RELATIONSHIP CODE _____

PHARMACY NAME _____

ADDRESS _____ SERVICE PROVIDER I.D. _____ QUAL (5) _____

CITY _____ PHONE NO. ( ) _____

STATE & ZIP CODE _____ FAX NO. ( ) _____

FOR OFFICE USE ONLY

WORKERS COMP. INFORMATION
EMPLOYER NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

CARRIER I.D. (6) _____ EMPLOYER PHONE NO. _____

DATE OF INJURY MM DD CCYY _____ CLAIM (7) REFERENCE I.D. _____

I have hereby read the Certification Statement on the reverse side. I hereby certify to and accept the terms thereof. I also certify that I have received 1 or 2 (please circle number) prescription(s) listed below.

PATIENT / AUTHORIZED REPRESENTATIVE _____

ATTENTION RECIPIENT PLEASE READ CERTIFICATION STATEMENT ON REVERSE SIDE

1

PRESCRIPTION / SERV. REF. #	QUAL (8)	DATE WRITTEN MM DD CCYY	DATE OF SERVICE MM DD CCYY	FILL#	QTY DISPENSED (9)	DAYS SUPPLY

PRODUCT / SERVICE I.D.	QUAL (10)	DAW CODE	PRIOR AUTH # SUBMITTED	PA TYPE (11)	PRESCRIBER I.D.	QUAL (12)

DUR/PPS CODES (13)	BASIS COST (14)	PROVIDER I.D.	QUAL (15)	DIAGNOSIS CODE	QUAL (16)
A B C					

OTHER PAYER DATE MM DD CCYY	OTHER PAYER I.D.	QUAL (17)	OTHER PAYER REJECT CODES	USUAL & CUST. CHARGE

1

	INGREDIENT COST SUBMITTED
	DISPENSING FEE SUBMITTED
	INCENTIVE AMOUNT SUBMITTED
	OTHER AMOUNT SUBMITTED
	SALES TAX SUBMITTED
	GROSS AMOUNT DUE SUBMITTED
	PATIENT PAID AMOUNT
	OTHER PAYER AMOUNT PAID
	NET AMOUNT DUE

2

PRESCRIPTION / SERV. REF. #	QUAL (8)	DATE WRITTEN MM DD CCYY	DATE OF SERVICE MM DD CCYY	FILL#	QTY DISPENSED (9)	DAYS SUPPLY

PRODUCT / SERVICE I.D.	QUAL (10)	DAW CODE	PRIOR AUTH # SUBMITTED	PA TYPE (11)	PRESCRIBER I.D.	QUAL (12)

DUR/PPS CODES (13)	BASIS COST (14)	PROVIDER I.D.	QUAL (15)	DIAGNOSIS CODE	QUAL (16)
A B C					

OTHER PAYER DATE MM DD CCYY	OTHER PAYER I.D.	QUAL (17)	OTHER PAYER REJECT CODES	USUAL & CUST. CHARGE

2

	INGREDIENT COST SUBMITTED
	DISPENSING FEE SUBMITTED
	INCENTIVE AMOUNT SUBMITTED
	OTHER AMOUNT SUBMITTED
	SALES TAX SUBMITTED
	GROSS AMOUNT DUE SUBMITTED
	PATIENT PAID AMOUNT
	OTHER PAYER AMOUNT PAID
	NET AMOUNT

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