

# NCPDP Universal Claim Form Sample

<input type="checkbox"/> CARDHOLDER I.D. _____ <input type="checkbox"/> CARDHOLDER NAME _____ <input type="checkbox"/> PATIENT NAME _____ <span style="font-size: small;">144</span> <input type="checkbox"/> PATIENT DATE OF BIRTH _____ MM DD CCYY <span style="font-size: small;">(PERF)</span> <b>PHARMACY</b> NAME _____  <b>ADDRESS</b> _____  <b>CITY</b> _____  <b>STATE &amp; ZIP CODE</b> _____		<b>GROUP</b> I.D. _____  <b>PLAN</b> <b>NAME</b> _____  <b>OTHER COVERAGE CODE (1)</b> _____ <b>PERSON CODE (2)</b> _____  <b>PATIENT (3)</b> <b>GENDER CODE</b> _____ <b>PATIENT (4)</b> <b>RELATIONSHIP CODE</b> _____  <b>SERVICE PROVIDER I.D.</b> _____ <b>QUAL (5)</b> _____  <b>PHONE NO.</b> ( ) _____  <b>FAX NO.</b> ( ) _____	 <span style="font-size: small;">Copyright © By NCPDP 1977, 1979, 1983, 1987, 1990, 2000</span> <b>NCPDP UNIVERSAL CLAIM FORM (UCF)</b> <span style="font-size: small;">144</span>																																																																																																	
<b>WORKERS COMP. INFORMATION</b> <b>EMPLOYER NAME</b> _____  <b>ADDRESS</b> _____  <b>CITY</b> _____ <b>STATE</b> _____ <b>ZIP CODE</b> _____  <b>CARRIER I.D. (6)</b> _____ <b>EMPLOYER PHONE NO.</b> _____  <b>DATE OF INJURY</b> _____ MM DD CCYY <b>CLAIM (7) REFERENCE I.D.</b> _____																																																																																																				
<small>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.</small> <small>PATIENT / AUTHORIZED REPRESENTATIVE _____</small>																																																																																																				
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