

Custom-made Compounded Medication Insurance Form

Patient name _____
Last Name First Name M.I.

Date of Birth ____/____/____

Cardholder _____
Last Name First Name M.I.

Cardholder ID # _____ Group # _____

Prescription # _____ Date filled _____ Days Supply _____

Quantity & Form _____ Retail Price \$ _____

Physician Name _____ DEA No. _____

Ingredient Name	NDC #	Dose
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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NABP# 0603387, NPI# 1757478992

Registered Pharmacist Number Date