HEALTH INFORMATION DESIGNS, INC
PRESCRIPTION DRUG MONITORING PROGRAM
AZCSPMP-UNIVERSAL CLAIM FORM

Please use this form to report the dispensing of a controlled substance.

Fax: (866) 422 3761
Phone: (800) 225 6998

Fax or Mail to
Health Information Designs

391 Industry Dr
Auburn, AL 36832

PATIENT INFORMATION

First Name _____ MI ____ Last Name _____

Telephone number _____

DOB _____/_____/_____ Gender ☐ M ☐F

Address _____ City _____ State _____ Zip _____

DISPENSER INFORMATION

Dispenser Name _____ NABP_____ DEA _____

Phone # (_____)_____-_____ Fax # (_____)_____-_____

Address _____ City _____ State _____ Zip _____

PRESCRIPTION INFORMATION

Prescription # 1

Rx # _____ Date Filled _____/_____/_____ Date Written _____/_____/_____ ☐ New ☐Refill

NDC ☐☐☐☐☐ - ☐☐☐☐ - ☐☐ Drug Name(Strength) _____

Quantity Dispensed _____ Days Supply _____ # Refills Left _____

Prescriber Name _____ State License # _____ DEA _____

Prescriber Phone # (_____)_____-_____ Prescriber Fax # (_____)_____-_____

Method of Payment PvtPay Mdcaid Mdcare PBM ins Maj Med WkCmp

Prescription # 2

Rx # _____ Date Filled _____/_____/_____ Date Written _____/_____/_____ ☐ New ☐Refill

NDC ☐☐☐☐☐ - ☐☐☐☐ - ☐☐ Drug Name(Strength) _____

Quantity Dispensed _____ Days Supply _____ # Refills Left _____

Prescriber Name _____ State License # _____ DEA _____

Prescriber Phone # (_____)_____-_____ Prescriber Fax # (_____)_____-_____

Method of Payment PvtPay Mdcaid Mdcare PBM ins Maj Med WkCmp ☐

Prescription # 3

Rx # _____ Date Filled _____/_____/_____ Date Written _____/_____/_____ ☐ New ☐Refill

NDC ☐☐☐☐☐ - ☐☐☐☐ - ☐☐ Drug Name(Strength) _____

Quantity Dispensed _____ Days Supply _____ # Refills Left _____

Prescriber Name _____ State License # _____ DEA _____

Prescriber Phone # (_____)_____-_____ Prescriber Fax # (_____)_____-_____

Method of Payment PvtPay Mdcaid Mdcare PBM ins Maj Med WkCmp

FOR HID USE ONLY

Date Received _____/_____/_____ Date Entered _____/_____/_____

Comments _____