



## PRESCRIPTION CLAIM FORM - DIRECT MEMBER REIMBURSEMENT

You will receive reimbursement for this claim at the allowed amount (less the copayment)

MAIL: VerusRx, LLC 8150 N. Central Expressway, Suite 1700 Dallas, TX 75206

FAX: 800-856-0327

- Keep a copy of all documents submitted for your records.
- Reimbursement is not guaranteed, and is subject to limitations, exclusions and provisions of the plan.
- Please allow up to 30 days from the time you send this form until the time you receive the response
- If you are submitting multiple claims; only one form is necessary.
- Please attach receipts, labels, and/or a printout from the pharmacy for verification

Member Information: This section must be fully completed to ensure proper reimbursement of your claim					
Member ID Number (refer to your benefits card):					
First Name:		Last Name:		MI:	Phone Number:
Address:			City:	State:	Zip Code:
Date of Birth:	<input type="radio"/> Male <input type="radio"/> Female	Relationship:	<input type="radio"/> Employee <input type="radio"/> Spouse	<input type="radio"/> Child	<input type="radio"/> Other:

### PLEASE ASK THE PHARMACIST TO COMPLETE THE PORTION BELOW

Pharmacist: A Universal Claim Form may be attached in place of filling out the form				
Date Filled:	Rx Number:	Quantity:	Day Supply:	NDC Number:
Drug Name, Strength, Dosage Form:			Prescriber's Name:	
Total Rx Price (including tax): \$			Prescriber's NPI or DEA #:	
Pharmacy Name:		NPI or NABP:		Pharmacy's Phone Number:
Pharmacist's Signature:				

### VERUS RX ELECTRONIC FUNDS TRANSFER AUTHORIZATION REQUIREMENT

Please check one:	<input type="checkbox"/> Checking	<input type="checkbox"/> Savings
Bank (Depository) Name: _____		
City: _____	State: _____	Zip: _____
Account Number: _____ Routing Number: _____		

I certify that I (or my eligible dependent) have received the medicine described herein. I certify that I have read and understood this form, and that all the information entered on this form is true and correct.

Member Signature:

Date: