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:	◯ Male ◯ Female	Relationship: ◯ Employee ◯ Spouse ◯ Child ◯ 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: ◯ Checking ◯ 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:**