RETIREE PRESCRIPTION CLAIM FORM - DIRECT MEMBER REIMBURSEMENT

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

MAIL: VerusRx, LLC Attn: DMR Department
12221 Merit Drive, Suite 1800, Dallas, TX 75251
FAX: 214-238-4439
EMAIL: DMR@Verus-Rx.com

- **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 thirty (30) days from the time you send this form until the time you receive a response.**
- **If you are submitting multiple claims, only one form is necessary.**
- **Please attach proof of purchase (i.e. 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: ○	

Payment Method: Check ○ ACH (Electronic Funds Transfer) ○

Account Type: Checking ○ Savings ○

Bank Name:

City: State: Zip:

Account Number: Routing Number:

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:				

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:**

Address: City: State: Spouse

Date of Birth: