



## 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 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: