P.O. Box 9780
Salt Lake City, UT 84109
Telephone: 877-879-9722

Prescription Reimbursement Claim Form

Member/Subscriber Information *See your ID Card*

Member Name (First, Last)	Member ID Number		
Mailing Address	**City**	**State**	**Zip**

Patient Information

Patient Name (First, Last)	Patient's Gender	Patient 's Date of Birth
	☐ Female ☐ Male	

Relationship of Patient to Subscriber

☐ Self ☐ Spouse ☐ Child ☐ Other

Does Patient have other prescription drug coverage:

☐ Yes ☐ No

If yes, these claims must be submitted with pharmacy receipt(s) identifying copays paid and an Explanation of Benefits from the primary carrier or a prescription history from the pharmacy showing insurance payment.

Prescription Information

Attach Original Pharmacy receipt(s) or Pharmacy Printout

The receipt(s) or printout should include the following:

- Date Rx Filled
- Rx Number
- Medication Name and Strength
- Quantity of medication received
- Day Supply of medication received
- 11 digit National Drug Code (NDC#)
- Member Paid Amount
- Pharmacy Name
- Pharmacy ID number
- Physician Name and/or DEA Number

Receipt(s) or pharmacy printout without complete pharmacy detail will not be processed and will not be returned. Please keep a copy, if needed.

I certify the above information, including accompanying statements, are to the best of my knowledge true, correct and complete. I authorize VRx, health care providers and/or persons or entities retained by VRx for the purpose of auditing claims to secure or release information relating to this claim.

Member/Subscriber Signature	Date