

# Adjustment to Account Request



Provider No.: \_\_\_\_\_ Contact Person: \_\_\_\_\_ (Print Name)

Pharmacy Name: \_\_\_\_\_ Pharmacy Telephone: \_\_\_\_\_

<p><b>Prescription to be reversed No. 1</b></p> <p>Rx No.: _____ Tx No.: _____</p> <p>Rx Date: _____</p> <p>DIN: _____</p> <p>Amount Paid by the Insurer: \$ _____</p> <p>Reason: _____</p> <p>_____</p> <p>_____</p> <p>18 Digit Card No.: _____ (Carrier, Group, Certificate)</p>	<p><b>Prescription to be reversed No. 2</b></p> <p>Rx No.: _____ Tx No.: _____</p> <p>Rx Date: _____</p> <p>DIN: _____</p> <p>Amount Paid by the Insurer: \$ _____</p> <p>Reason: _____</p> <p>_____</p> <p>_____</p> <p>18 Digit Card No.: _____ (Carrier, Group, Certificate)</p>
<p><b>Prescription to be reversed No. 3</b></p> <p>Rx No.: _____ Tx No.: _____</p> <p>Rx Date: _____</p> <p>DIN: _____</p> <p>Amount Paid by the Insurer: \$ _____</p> <p>Reason: _____</p> <p>_____</p> <p>_____</p> <p>18 Digit Card No.: _____ (Carrier, Group, Certificate)</p>	<p><b>Prescription to be reversed No. 4</b></p> <p>Rx No.: _____ Tx No.: _____</p> <p>Rx Date: _____</p> <p>DIN: _____</p> <p>Amount Paid by the Insurer: \$ _____</p> <p>Reason: _____</p> <p>_____</p> <p>_____</p> <p>18 Digit Card No.: _____ (Carrier, Group, Certificate)</p>

**Fax this form to 1-866-977-7717 - Attention "Audit Department"**

By signing this document, you authorize TELUS to take funds from your current provider number for any claim you want to void that was processed with a de-activated provider number.

Date of Request: \_\_\_\_\_ Signature: \_\_\_\_\_

**Print**