PRO ACT
PHARMACY BENEFIT MANAGEMENT

DIRECT MEMBER REIMBURSEMENT FORM

1. Please complete all information in part A.
2. Complete Part B using the information on the pharmacy monograph.
3. **Attach pharmacy receipt & monograph for each claim submitted.**
4. Review, sign, and send to ProAct via one of the options below**:**

Mail: ProAct, Inc.
1230 US HWY 11
Gouverneur, NY 13642
Attn: DMR Dept.

Fax: (315) 287-7864

Email: dmr@proactrx.com

IMPORTANT: MISSING INFORMATION MAY CAUSE A DELAY IN PAYMENT.

PART A – Employee/Patient Information

Employee's Name: Last First	**Member # (on ID Card)**
Patient's Name: Last First	**Relationship to Employee**
Employee's Street Address	**Group ID# (on Card) Employer/Carrier**
City State Zip Code	**Employee's Daytime Phone #** ( )

Please indicate why the patient paid in full: _____

PART B – Prescription Information

Rx #	Rx Date	NDC Number	Quantity	Days Supply	Amt Paid	Copay	Member Reimbursement

Authorization: I certify that the above statements are correct and hereby authorize any physician, hospital, employer, union, insurance company, pharmacist, HMO, or prepayment organization to supply the Plan Administrator and its agents any information required with this claim. A photocopy of this claim shall be valid as the original.

Signature_____ **Date**_____

This form is approved for processing (please circle one) **YES** **NO**

Signature_____ Date_____