PRO ACT
PHARMACY BENEFIT MANAGEMENT

DIRECT MEMBER REIMBURSEMENT FORM

INSTRUCTIONS:

1. Please complete all information in Part A.
2. Please complete Part B using the information on the pharmacy monograph.
3. **Attach pharmacy receipt & monograph for each claim submitted.**
4. Review, sign, and return to ProAct via one of the options below within 365 days of purchase*:

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

Please indicate why the patient paid in full: _____

_____

*If a claim was rejected at the pharmacy for prior authorization, a prior authorization must be processed and approved within 30 days of purchase for possible reimbursement.

PART B – Prescription Information

						FOR PROACT'S USE ONLY	
Rx #	Rx Date	NDC Number	Quantity	Days Supply	Amount 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: _____