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 packaging of your prescription, your receipt, or from your pharmacist.
3. **Attach Pharmacy Receipt for each claim submitted**
4. Review, sign, and send to**:**

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

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_____

For ProAct Use Only

Date Processed _____ Processor's Initials_____ Transmittal #_____ Status _____

Invoice #_____ Date Chk Issued: _____ Check #_____ Date Chk Mailed: _____

- PLEASE ATTACH PHARMACY RECEIPTS-