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 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 |
|---|---|---|---|---|---|---|---|
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**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**_____