



**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**

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

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

<b>Date Processed</b> _____	<b>Processor's Initials</b> _____	<b>Transmittal #</b> _____	<b>Status</b> _____
<b>Invoice #</b> _____	<b>Date Chk Issued:</b> _____	<b>Check #</b> _____	<b>Date Chk Mailed:</b> _____

**- PLEASE ATTACH PHARMACY RECEIPTS-**