



**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. Review, sign, and send to:

**ProAct Pharmacy Services, 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 Car
Patient's Name: Last	First	Relationship to Employee
Employee's Street Address		Group ID#(on Card) Employer/Carrie
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 \_\_\_\_\_

Date Processed \_\_\_\_\_ Processor's Initials \_\_\_\_\_ Transmittal # \_\_\_\_\_ Status \_\_\_\_\_

Invoice # \_\_\_\_\_ Date Chk Issued: \_\_\_\_\_ Check # \_\_\_\_\_ Date Chk Mailed: \_\_\_\_\_

**- PLEASE ATTACH PHARMACY RECEIPTS-**