

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 via one of the options below:

**Mail:** ProAct, Inc.                      **Fax:** (315) 287-7864                      **Email:** dmr@proactrx.com  
 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
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 \_\_\_\_\_