EQUITY-LEAGUE BENEFIT FUNDS
PENSION, HEALTH & 401(K)

PRO ACT
PHARMACY BENEFIT MANAGEMENT

OUT-OF-NETWORK PHARMACY 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 that was filled within 12 months of the prescription date.**
4. Review, sign, and mail to**:** **ProAct Inc.**
1230 US HWY 11
Gouverneur, NY 13642
Attn: DMR Dept.

IMPORTANT: MISSING INFORMATION MAY CAUSE A DELAY IN PAYMENT. IF YOU NEED ASSISTANCE COMPLETING THIS FORM, CONTACT YOUR PHARMACIST.

For any questions, please call ProAct directly at (833) 636-1400.

PART A– Participant/Patient information

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

Please indicate why the patient paid in full: ____

PART B - Prescription Information

Rx #	Rx Date	NDC Number	Quantity	Days Supply	Amount Paid		

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**___________________________________

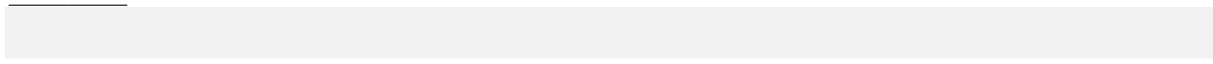
This form is approved for processing (please circle one) **YES** **NO**

Signature____ **Date**_____________________________________

For ProAct Internal Use Only

Date Processed _____________ **Processor's Initials**__________ **Transmittal #**___________ **Status** ___________

Invoice #____________________ **Date Chk Issued:** ___________ **Check #**________________ **Date Chk Mailed:** __________



- PLEASE ATTACH PHARMACY RECEIPTS-