

If submitting a reimbursement for a COVID-19 Home Test Kit, please DO NOT fill out Part B below. Complete Part A and attach a receipt that includes the name of the retail store, the quantity purchased, and the total cost.

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.**
3a. For COVID-19 Home Test Kits, you only need to attach the receipt.
4. Review, sign, and send to ProAct via one of the options below:

Mail: ProAct, Inc.
1230 US HWY 11
Gouverneur, NY 13642
Attn: DMR Dept.

Fax: (315) 287-7864

Email: dmr@proactrx.com

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 ID Card, Employer/Carrier)
City	State	Zip Code	Employee's Daytime Phone #

Please indicate why the patient paid in full: _____

DO NOT fill in the below prescription information if submitting for COVID-19 Home Test Kits.

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 check one) **YES** **NO**

Signature _____ **Date** _____