PROACT®

PHARMACY SERVICES

ORDER FORM REQUEST

Please complete and return form to
ProAct Pharmacy Services
1226 US Highway 11
Gouverneur, NY 13642
1-866-287-9885 or 315-287-3000

Member ID # _____ Company Employed or Retired From _____

Ship To:

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____

E-Mail Address _____

Please ensure DOB's are on the prescriptions being mailed to the pharmacy, so as not to delay processing time.

Comment/Refill Request:

_____

_____

_____

Prescriptions Enclosed For:

Name _____ Date of Birth _____ # of Prescriptions _____

Name _____ Date of Birth _____ # of Prescriptions _____

Total Number of Prescriptions Enclosed: _____

Method of Payment: (Please Check The Box Below)

Check or Money Order_____MasterCard_____Visa_____Discover_____American Express_____

Credit Card Number _____ Expiration Date _____

Child Proof Caps Please Indicate: (Circle) Yes or No

Receipt of Privacy Practice
I acknowledge receipt of the ProAct Pharmacy Services Notice of Privacy Practices

_____

Signature of Insured Family Member Printed Name of Insured Family Member Date