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