ProCare Rx

Prescription Reimbursement Form

Date: _____

Please fill out the following information and return to us as indicated below.

A. Member Information

Cardholder Name:		Cardholder ID #:
Cardholder Phone #:	Plan Name:	Group #:

B. Reason for Reimbursement

- ☐ Compound Medication
- ☐ No ID Card
- ☐ Other, please explain:
- ☐ COBRA Request
- ☐ Eligibility Data Error

C. Reimbursement Mailing Instructions

Address:	City:	State:	Zip:

D. Prescription Information

Date of Service	Prescription #	Medications

When complete, please return this document, along with the pharmacy register receipt and prescription label to:

Mail:
ProCare Rx
ATTN: Prescription Reimbursement Department
26711 Northwestern Highway, Suite 500
Southfield, MI 48033

OR

Fax:
248-948-9904

Email:
rxreimbursements@procarerx.com

FOR INTERNAL USE ONLY

Reimbursement Amount: $

Notes: