2019 Medicare Part D
Prescription Information

In response to your request to research Prescription Drug Benefits through Medicare Part D or Medicare Advantage plans, you are **voluntarily** releasing the following information to our office. Please sign and date at the bottom of this form.

Instructions: Please do NOT list over-the-counter medications or vitamin supplements. Write legibly and DO NOT state "As Needed" for any medication. Give us your best estimate for how many refills you use during the year, as we cannot provide accurate recommendations without this information. Please list the drug's suffix and form as well.

Name:	Date of Birth:	Zip Code:
Preferred Pharmacy:		

#	**Medication Name** (Please check spelling on current prescription bottle and list suffix, i.e. HCL, ER, HCTZ)	**Form** (i.e. liquid, tablet, creme, drop, ointment)	**Brand or Generic**	**Dosage** (i.e. 20 mg)	**Frequency taken** (i.e. daily, 3x daily, etc., **estimate monthly quantity for "as needed"**)
1					
2					
3					
4					
5					

Name:	Date of Birth:	Zip Code:
Preferred Pharmacy:		

#	**Medication Name** (Please check spelling on current prescription bottle and list suffix, i.e. HCL, ER, HCTZ)	**Form** (i.e. liquid, tablet, creme, drop, ointment)	**Brand or Generic**	**Dosage** (i.e. 20 mg)	**Frequency taken** (i.e. daily, 3x daily, etc., **estimate monthly quantity for "as needed")**
1					
2					
3					
4					
5					

This information will be held in strict confidence and will only be used by our office to determine which Medicare Part D plan to recommend based on your prescription needs. We will use the Medicare.gov website as a tool to make our suggestions. You have my (our) permission to phone us to arrange a meeting time or discuss the options:

Signature of Medicare Beneficiary

Date

☐ I don't take any prescriptions

Phone