Take the following information DIRECTLY from YOUR MEDICARE CARD and write neatly:

Name: _____ Medicare #: _____

Address: _____ Part-A date:_____ Part-B date: _____

City: _____ Zip _____ Birth Date: _____/_____/_____

Phone: _____ Phone: (other)_____

Prescriptions ONLY – not over the counter medicines

Drug Name (Example ELIQUIS)	Strength Example 5mg	Dosing Example 1/day	Drug Name (Example ELIQUIS)	Strength Example 5mg	Dosing Example 1/day
1			9		
2			10		
3			11		
4			12		
5			13		
6			14		
7			15		
8			16		

Local Pharmacy you use:_____ Are you eligible for any type of Medicaid Services? YES NO

Primary Physician:_____

Specialists:_____ Do you get "Extra Help" with Part D premiums? YES NO

_____ What kind of policy do you have? HMO/PPO Part D

_____ Name of plan(s)_____