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

Name:	The state of the s	ы	Medicare #:	17. 1017-1017-017-017-017-017-017-017-017-01	чиналични
Address:		Ŧ	Part-A date:Part-B date:	Ċ:	
City:	Zip	jegrej	Birth Date://		
Phone:	Phone: (other)				
	Prescriptions	ONLY - no	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 I/day
<u></u>			9		
2	1177		10		
رى			}		
4	AAAA	713 to 113 to 1	12		
5	ar minovanova.		13		
6	The Additional Association and		14		
7	TTOTAL	Annual Paris	15		
8			16		
Local Pharmacy you use:		Are	Are you eligible for any type of Medicaid Services? YES		NO
Primary Physician:	The state of the s	I			
Specialists:		_ Доу	Do you get "Extra Help" with Part D premiums?	YES	NO
		_ Wha	What kind of policy do you have? HMO/PPO Part D	Part D	
en de la companya de	Mary designation of the control of t	_ Nam	Name of plan(s)		