NAME: _____

Medicare PART D - Prescription Drug List

In order for us to do the best job possible for you, please provide us with the following:

1.) **The EXACT RX NAME, all words, with any initials after it**

2.) **Exact SPELLING is important: if you take the generic, give us THAT name**

3.) **Need EXACT DOSAGE, mg's, mcg's, solution, cream, or injection**

4.) **How often taken… (FREQUENCY) 1 per day, 2 per day, 3 times a week, etc..occasionally**

5.) **Please provide the name & Telephone # of the Pharmacy you use primarily!!**

6.) **Return to us via FAX: (973) 492-9068 or E-MAIL: TeamBetsy@MICInsurance.com**

* * **PHARMACY USED:** _____

PHARMACY Telephone: _____

* * **Date of Birth:** _____

* * **Zip Code:** _____

	Medication NAME - YOU TAKE	DOSAGE	FREQUENCY	GENERIC	BRAND	COMMENTS / NOTES
Ex:	*Metropolol Succinate ER*	*10 mg*	*1 per day*	*Please specify*		
	Lipitor	*20 mg*	*1 per day*	*by checking in the*		
	Prednisone	*10mg*	*Occasionally*	*corresponding box*		
1.)				❑	❑	
2.)				❑	❑	
3.)				❑	❑	
4.)				❑	❑	
5.)				❑	❑	
6.)				❑	❑	
7.)				❑	❑	
8.)				❑	❑	
9.)				❑	❑	
10.)				❑	❑	
11.)				❑	❑	
12.)				❑	❑	
13.)				❑	❑	
14.)				❑	❑	
15.)				❑	❑	