Your Name: _____DOB_____Home zip code_____Medicare A effective date:_____

Plans you are considering:_____Medicare B effective date:_____

Please provide information on the doctors you see regularly below

	Doctor First Name	Doctor Last Name	Practice Name if Applicable	Specialty	Address(town)
1					
2					
3					
4					
5					
6					
7					

Please be as detailed as possible with medication information.

	Drug Name	Brand or generic	Doseage/mg.	How many daily
1				
2				
3				
4				
5				
6				
7				

Preferred Hospital

Retail or Mail Order: _____
Pharmacy Name: _____

Additional Notes: