Prescription Drug Plan Search

Please use an additional sheet of paper if necessary.

Client Name: ______________________________ **Current Drug Coverage:** ______________________________

Client Address: ______________________________________ **Client State:** ______ **Client Zip Code:** __________

Client County: ______________________________ **Client Phone Number:** ______________________________

Client Email Address: ___________________________________

Requested Effective Date for Rx Plan: ____ /01/____ **Medicare Effective Date:** **Part A** ____ /01/____ **Part B** ____ /01/____

What is the client's reason for requested enrollment?

New to Medicare Retirement Annual Enrollment Period New to State Other ____________________

Preferred Pharmacy(s) First: ______________________________ Second: ______________________________

Does your client prefer mail-order prescriptions? Yes No

How often does the client prefer to fill their prescription(s)? 30 days 90 days Other __________________

Drug Name	Can the generic be taken? (if applicable)	Drug Format Type (tab, cap, cream, patch, vial, pen, etc)	Dosage	Quantity	Frequency Drug Needs Taken
	Yes No				
	Yes No				
	Yes No				
	Yes No				
	Yes No				
	Yes No				
	Yes No				
	Yes No				
	Yes No				
	Yes No				
	Yes No				
	Yes No				
	Yes No				
	Yes No				
	Yes No				
	Yes No				
	Yes No				

FOR AGENT USE ONLY

Drug List Source: __________________ **Drug List ID/Quote #:** ______________ **Drug Quote Date:** __________

(Medicare.gov or other drug-pricing tool)