

**2012 Medicare Part D
Prescription Information**

Name:		Date of Birth:		Zip Code:
#	Medication Name	Brand or Generic?	Dosage (i.e. 20 mg)	Frequency taken (i.e. daily, 3x daily, etc., estimate monthly quantity for "as needed")
1				
2				
3				
4				
5				
6				

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1				
2				
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This information will be held in strict confidence and will only be used by our office to determine which Medicare Part D plan to recommend based on your prescription needs. We will use the Medicare.gov website as a tool to make our suggestions.

You have my (our) permission to phone us to arrange a meeting time or discuss the options:

Signature of Medicare Beneficiary

Date

Phone