Prescription Drug List for 2017 and information for comparison of Part D Drug Plans

Plan information comes from www.medicare.gov

Pat's Medical Insurance Counseling

I will need ALL the information below if you would like me to accurately compare plans. By completeting this form it takes less time to do an accurate comparison. I do NOT need over the counter drugs.

Date: _____

Person taking drugs (as shown on medicare card): _____ **Phone:**_____ **Fax:** _____

Address--Street: _____**City:** _____ **State:** _____ **Zip:** _____

Medicare ID#:_____**Part A effective date:**_____ **Part B effective date:** _____**DOB:** _____

Name of current drug plan: _____ **Email:** _____

1st choice pharmacy: _____**2nd choice pharmacy:**_____

Do you want your premium deducted from your Social Security? _____ **Do you want mail order?**_____ **Do you get extra help?**_____

I understand that I can get a free comparison, but I agree to pay Pat to do it. **Initial:** _____

Please mark brand name only, if required.

NAME OF DRUG: (Show all information on the label)	**DOSAGE**	**<----TIMES TAKEN---->**			**Brand**	**Refill**	**Refill**	**Refill**	**Refill**
List the drugs that you expect to take in 2016.	**SIZE**	**DAILY**	**WEEKLY**	**MONTHLY**	**Only?**	**Pills**	**Drops**	**Inhalers**	**Injections**
I do not need over the counter drugs.									
Example: Niaspan ER Tab (ABBO)	1000MG	1			**X**	**90 days**			
Example: Advair HFA AER, puffs	**230/21**	8						**12 GM/30 Days**	

Pat's Medical Insurance Counseling
221 Feather Ct, Lincoln, CA, 95648 Phone: 916-408-0411,
Fax: 916-408-1144, Email: pat@patstoby.com, www.patsmedicalinsurancecounseling.com