## **List of CURRENT Prescription Medications**

Informed Choice Insurance Agency 877-446-3676 www.informedchoice.com

Address: County:  Medicare ID Number: Sales Agent:  Email Address: Appointment:  Current Plan Name: Preferred Retail Pharmacy:  Are you willing to switch to a different Pharmacy to save money? (check one) Yes No Are you willing to use a Mail Order Service? (check one) Yes No Are you willing to use a Mail Order Service? (check one) Yes No Are you willing to use a Mail Order Service? (check one) Yes No Are you willing to use a Mail Order Service? (check one) Yes No Are you willing to use a Mail Order Service? (check one) Yes No Are you willing to use a Mail Order Service? (check one) Yes No Are you willing to use a Mail Order Service? (check one) Yes No Are you willing to use a Mail Order Service? (check one) Yes No Are you willing to use a Mail Order Service? (check one) Yes No Are you willing to use a Mail Order Service? (check one) Yes No Optional – used to help determine potential eligibility for prescription assistance programs	Client Name:		For Office Us	For Office Use Only	
Email Address:  By providing your email address you are consenting to communication from your agent via email  Current Plan Name:  Are you willing to switch to a different Pharmacy to save money?  Are you currently using a Mail Order service? (check one) Yes  No  Are you willing to use a Mail Order Service? (check one) Yes  No  Average Household Annual Income:	Address:		County:		
By providing your email address you are consenting to communication from your agent via email  Current Plan Name:  Are you willing to switch to a different Pharmacy to save money?  Are you currently using a Mail Order service? (check one) Yes  No  Are you willing to use a Mail Order Service? (check one) Yes  No  Average Household Annual Income:	Medicare ID Number:		Sales Agent:		
Current Plan Name:  Are you willing to switch to a different Pharmacy to save money?  Are you currently using a Mail Order service? (check one) Yes  No  Are you willing to use a Mail Order Service? (check one) Yes  No  Are you willing to use a Mail Order Service? (check one) Yes  No  Average Household Annual Income:	Email Address:		Appointment:		
Are you willing to switch to a different Pharmacy to save money? (check one) Yes \( \Boxed{\text{No}}\) No \( \Boxed{\text{No}}\)  Are you currently using a Mail Order service? (check one) Yes \( \Boxed{\text{No}}\) No \( \Boxed{\text{No}}\) Are you willing to use a Mail Order Service? (check one) Yes \( \Boxed{\text{No}}\) No \( \Boxed{\text{No}}\)  Average Household Annual Income:	By providing your email address you are consenting to com-	nmunication from your agent via ema	uil		
Are you currently using a Mail Order service? (check one) Yes \( \Boxedot\) No \( \Boxedot\) Are you willing to use a Mail Order Service? (check one) Yes \( \Boxedot\) No \( \Boxedot\) Average Household Annual Income:	Current Plan Name:				
Average Household Annual Income:	Are you willing to switch to a different Pharmacy to save m	noney? (check one) Yes $\square$	No 🗆		
	Are you currently using a Mail Order service? (check one	Yes No Are you	ı willing to use a Mail Order Service	? (check one) Yes \( \square\) No \( \square\)	
* Do <u>NOT</u> include over-the-counter medications * If you are unsure what to write down, copy the label on your prescription bottle exactly	* Optional – used to help determine potential eligibility for		y the label on your prescription bott	le exactly	
Medication Name Dosage/Form/Size How often to you take it? How often is it filled?	Medication Name	Dosage/Form/Size	How often to you take it?	How often is it filled?	
Example: Triamcinolone Acetonide Topical .1% Ointment, 80 gm Tube Every other day Every 6 months	Example: Triamcinolone Acetonide Topical	.1% Ointment, 80 gm Tube	Every other day	Every 6 months	
Example: Simvastatin 20 mg Tablet Once a day Every month	Example: Simvastatin	20 mg Tablet	Once a day	Every month	
			· ·	Every month	
				Every month	
				Every month	
				Every month	
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