List of CURRENT Prescription Medications

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

For Office Use Only	
County:	
Sales Agent:	
Appointment:	

Client Name: _____

Address: _____

Medicare ID Number: _____

Email Address: _____

By providing your email address you are consenting to communication from your agent via email

Current Plan Name: _____ Preferred Retail Pharmacy: _____

Are you willing to switch to a different Pharmacy to save money? *(check one)* Yes ☐ No ☐

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: _____

** Optional – used to help determine potential eligibility for prescription assistance programs*

** Do **NOT** include over-the-counter medications * If you are unsure what to write down, copy the label on your prescription bottle exactly*

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: *Simvastatin*	*20 mg Tablet*	*Once a day*	*Every month*

You are not required to provide this information in order to meet with a Sales Agent