Medication List

Medicare Part D

Name:_____ Date of Birth:_____
Address_____ Phone:_____
City,State,Zip:_____ Email:_____

Pharmacy 1:_____Medicare.gov Username_____Date_____
Pharmacy 2:_____Password:_____Mail Order Option needed? Y/N

We will contact you to discuss the results and help enroll you in the best plan.

Hint: Copy medication names directly from the bottle. There may be a substantial price difference between brand and generic medications
MISSING/INCORRECT INFO WILL RESULT IN DELAYS AND INCORRECT RESULTS

Medication Name	Brand/Generic	Dosage	Frequency	Days Supply

Return the FULLY completed form to: **faye@insshops.com**
or Fax: **800-901-1699**
or Mail: **Insurance Shops, 246 Bustleton Pike, Feasterville PA 19053**

For questions Call us at: **215-613-4999**

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