List of Medications and Dosages

LOCAL HELP FOR PEOPLE WITH MEDICARE

Name: _____ **DOB:** _____

Address: _____

Medicare #: _____ **Part A begin Date:** _____ **Zip Code:** _____

Preferred Pharmacy: (1) _____

(2) _____

(3) _____

Would you consider a Mail Order Pharmacy? _____**YES** _____**NO**

Current Plan Name: _____

Medicare.gov log-in _____ **Password** _____

	Prescription Drug Name	Dosage (mg, mcg, ml, vial, tube)	Pills / month (number per day X 30)
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			