Name:_____

Phone: _____

Email: _____

2027 office use
Date Received_____
Review: Good Need appt
Appt date:_____
Scope: Paper Online

Preferred method of contact: Phone_____ Text_____
Email_____ Any_____

1. How do you feel about your current plan?

_____a. Would like to stay with the plan.

_____b. Like the drug plan but would change plans if I save money

_____c. Definitely want to change the drug plan

Main reason you want to change plans_____

2. What are your current prescriptions?
People usually remember to list all their prescription tablets and capsules but often forget to include things like their insulin, nasal sprays, asthma inhalers, creams and ointments.

DON'T include medications that are OTC (over the counter) or you get at the VA or that Worker's Comp pays for

Drug	Strength	Form (tab, cap, spray etc)	How often

Preferred Pharmacy_____

3. Do you receive Extra Help for your prescriptions:

_____ Yes _____ No

Additional comments:_____

_____