Prescription Medication Sheet

Date Recieved:

Section A

Name _____ *Phone* _____

Email _____

Current Drug Plan Name _____

Monthly Plan Cost _____ *Current Pharmacy* _____

Preferred Pharamacy _____

☐ ***I currently do not take any medications.***
Please skip Section B, read & sign Section C below

☐ ***I have attached a complete list of all prescription medications to this form.***
Please skip Section B, read & sign Section C below

Section B

NAME OF MEDICATION	DOSAGE (mg)	TIMES PER DAY	DATE PRESCRIBED

If you have any additional medications please continue on the back of this paper. →

Section C

By signing below, I attest that the prescription drug information that I have provided is accurate and complete. I further attest that if I omit medications and my Part D prescription drug costs for 2022 are higher than anticipated, I agree to hold harmless, The Benefit Partners, Inc DBA Senior Insurance & Retirement Advisors and it's licensed agents.

Signature _____ *Date* _____

Additional Medications

NAME OF MEDICATION	DOSAGE (mg)	TIMES PER DAY	DATE PRESCRIBED