Name: _____

Phone #: _____

Date of Birth: _____

Zip Code: _____ County:_____

Tobacco Usage in the Past 12 Months? ___ YES ___ NO

Do you have End Stage Renal Disease (ESRD)? ___ YES ___ NO

Is your gross annual income **BELOW**
$18,090 (if single) or $24,360 (if married)? ___ YES ___ NO

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Drug List ID: _____

Password: _____

☐ IEP ☐ AEP ☐ SEP

Plan Year: _____

Prescription Medications you REGULARLY take:

Do not include vitamins, supplements, or any short term medications (i.e. antibiotics)

	Name of Drug	Strength	Daily Quantity	Refill Qty: 30 or 90 days	Monthly # Vials/Tubes	Vial/Tube Size	Generic, Brand Name, or VA?
Ex	**Metformin**	**500 mg**	**2**	**30**	**n/a**	**n/a**	**generic**
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							

YES	NO	Current Coverage
		Do you have TriCare for Life?
		Do you have coverage through the Veteran's Administration (VA)?
		Are you currently on Medicaid? *(government health coverage for low-income individuals)*
		Are you and your spouse covered under the same group plan? If yes, who is the primary insured? _____
		Are you currently enrolled in a Medicare Supplement, Medicare Advantage Plan, and / or a Medicare Prescription Drug plan? If yes, plan name: _____

Primary Care Physician

Are you willing to change?

Dr. Name: _____

Practice Name: _____ **YES** **NO**

Phone Number: _____

Specialists

Specialty: _____

Dr. Name: _____

Practice Name: _____ **YES** **NO**

Phone Number: _____

Specialty: _____

Dr. Name: _____

Practice Name: _____ **YES** **NO**

Phone Number: _____

Specialty: _____

Dr. Name: _____

Practice Name: _____ **YES** **NO**

Phone Number: _____

Preferred Pharmacy

Name: _____

Address: _____ **YES** **NO**

Preferred Hospital for In-Patient Services

Name: _____

Address: _____ **YES** **NO**

OFFICE USE ONLY

_____

_____

_____

_____