MEDICATION AND PROVIDER LIST

Please fill out the following information regarding your medications and doctors. It is important to know the dosage and how they are scheduled. This will help determine which plan will fit your medications best and qualify if your doctors are in network.

Name: _____ Zip Code: _____ Pharmacy: _____

Do you receive any of the following: (Please check all that apply)

QMB ☐ QI ☐ DEL ☐ ME RX ☐

(aka Medicare Buy-In or Extra Help)

Name of Medications (TAB, CAP, ER, SR)	Strength of Medications	How many Per Day

PCP (personal Care Physician): _____

Dentist: _____

Vision Doctor: _____

Hearing Doctor: _____

Specialists: _____

_____