

2020 PART D REVIEW REQUEST



Name: _____

Phone: _____ Email Address: _____

Zip Code: _____ Best Time to Reach Me: _____

Current Part D Company: _____ Current Medicare plan or Supplement: _____

Preferred Pharmacy: _____ Date of Birth: _____

Do you have Senior Care? Yes No

Annual household income ((optional-to check if you qualify for help): \$ _____

If you have one, please provide your **My Medicare** account information:

Username: _____

**FOR MORE INFORMATION ABOUT CREATING
YOUR MY MEDICARE ACCOUNT [CLICK HERE](#)**

Password: _____

Please use the worksheet below to provide us with a list of your current medications.

| NAME OF MEDICATION | DOSAGE | FREQUENCY | HOW OFTEN IS THE PRESCRIPTION FILLED? |
|---|---------|------------------|---------------------------------------|
| EXAMPLE: Simvastatin Tablets | 20 mg | Once a day | 90 pills every 3 months |
| EXAMPLE: Humalog 50/50 Kwikpens | 3mL Pen | 50 Units per day | Pkg of 5 pens lasts 1 month |
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**SCAN AND EMAIL COMPLETED REQUEST FORM TO: AL@FRANKINSURANCEWI.COM
OR Mail completed request form to:**

**Frank Insurance Group LLC
7818 Big Sky Dr Ste 204
Madison, WI 53719**

We will reach out to you with our recommendation after we have had a chance to review.