Prescription Drug List for 2017 Annual Enrollment

Full Name as it appears on your

Medicare Card:_____

Address:_____ **City:**_____ **Zip:**_____

Phone#:_____ **Birth Date:** _____

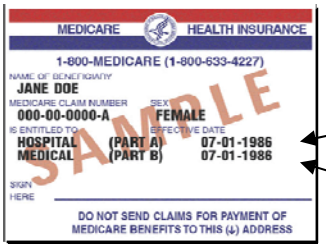
Medicare#: _____

Hospital Part A Effective Date (on Medicare Card):_____

Medical Part B Effective Date (see Medicare Card):_____

Preferred Pharmacy & Location: _____

_____



Optional: **Is your Medicare Card worn or hard to read? If so, list your Social Security Number and we will have a new card sent to your address: Soc. Sec. #**_____

	Print Full Drug Name – or Attach a list from your pharmacy	Dosage (mg strength)	Frequency (times per day)
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			

I give my consent for Appalachian Benefits Counselors to assist me with my 2016 Medicare Coverage using the above information.

Sign Above: Date:

SMP Empowering Seniors To Prevent Healthcare Fraud

Fax or Mail this form to:

Appalachian ADRC
PO Box 6668
Greenville, SC 29606
Fax: (864) 242-6957