Prescription Drug List for 2017 Annual Enrollment

Full Name as it appears on your

iviculture .	Card:		
Address:		City:	Zip:
Phone#:		Birth Date:	
Medicare	#:		
Hospital Part A Effective Date (on Medicare Card): Medical Part B Effective Date (see Medicare Card):			MEDICARE 1-800-MEDICARE (1-800-633-4227) NAME OF EXPERIMENTY JANE DOE MEDICARE CLAN MANDER 5EX FEMALE FOR A DOE MEDICARE Part A Date MEDICAL PART B 07-01-1986 MEDICAL PART B O7-01-1986
Preferred	Pharmacy & Location:		Part B Date DO NOT SEND CLAIMS FOR PAYMENT OF MEDICARE BENEFITS TO THIS (4) ADDRESS
have a nev	<u>//:</u> Is your Medicare Card worn or hard to row 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	your pharmacy	(ing strength)	(times per day)
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
	consent for Appalachian Benefits Counselo ledicare Coverage using the above information		Fax or Mail this form to: Appalachian ADRC PO Box 6668 Greenville, SC 29606 Fax: (864) 242-6957
Sign A	above: Date:	Empowering Seniors To Prevent Healthcare Fraud	(00.) = 1= 0001