

Prescription Drug List for 2016 Annual Enrollment

Full Name as it appears on your

Medicare Card: _____

Address: _____ City: _____ Zip: _____

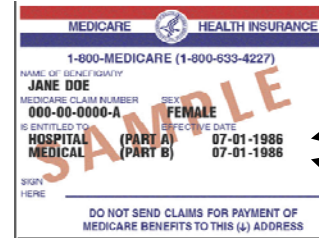
Phone#: _____ Birth Date: _____

Medicare#: _____

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

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

Preferred Pharmacy & Location: _____



Part A Date

Part B Date

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 Below:

Date:

Fax or Mail this form to:
Appalachian ADRC
PO Box 6668
Greenville, SC 29606
Fax: (864) 242-6957