Kristin Manwaring Insurance

For office use only:

Appointment Date & Time	_____-_____-_____/_____:_____
Enrollment Period/Effective Date	
Date Received	

Medicare Part D Prescription Questionnaire

Name (First, MI, Last):_____ Preferred/Nickname: _____

Phone Number: _____ Email Address: _____

Physical Address: Street_____City_____State_____Zip Code_____

Mailing Address: Street/PO_____City_____State_____Zip Code_____

Preferred Pharmacy: 1) _____ 2) _____

Do you also use a Mail Order Pharmacy? **Yes** ☐ **No** ☐

Current / Existing Medicare Coverage:

Do you currently have existing Medicare Insurance Coverage? If yes, please state your existing plan name(s) below:

Yes ☐ **No** ☐ **Part D Prescription Drug Plan:** Insurance Company:_____ Plan Name: _____

Yes ☐ **No** ☐ **Medicare Advantage Plan:** Insurance Company:_____ Plan Name: _____

Yes ☐ **No** ☐ **Medicare Supplement:** Insurance Company:_____ Plan Name: _____

Current Medications / Prescription List:

- **Prescription Name**: It is very important to copy the entire name of your prescription exactly as shown on the bottle.
  - Give us the Generic Name if you take the Generic version.
  - Give us the Brand Name if you take the Brand Name.
- **Strength/Dosage:** Note the strength. Such as 20mg, 3 ML, 50-12.5, etc.
- **Quantity/Size:** Note the amount provided when refilled. Such as pens per box, pills per bottle, size of container, etc.
- **Form**: Note the form of medication. Such as Tablet, Capsule, Inhaler, Flexpen, Gel, Cream, etc.
- **Frequency:** Note how often you purchase the prescription. Such every 1 month, 2 months, 3 months, 12 months, etc.

	Prescription Name	Strength/ Dosage	Quantity/Size	Form	Frequency of Purchase
	(example) Albuterol - Ventolin		18GM	Inhaler	Once every 3 months
	(example) Lisinopril	20mg	30 count	Tablets	Monthly
1					
2					
3					
4					
5					
6					
7					

Quotes provided are estimates only

2300 South Park Avenue | Port Townsend, WA 98368 | (360) 385-4400 | (800) 643-3590

Kristin Manwaring Insurance

Medicare Part D Prescription Questionnaire

	Prescription Name	Strength	Amount in Bottle/ Size of Container	Form	Frequency of Purchase
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					
25					

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