Medicare Part D worksheet Year: _____

Name: _____

Best Contact Phone #: _____

Date of Birth: _____

County: _____ Zip Code: _____

Pharmacy name _____

Initial Contact: _____ Part D plan name _____

For a Generic drug list generic name. For a Brand drugs list Brand name.

	Drug Name	Dosage	Frequency	RX Type (eg: tab, capsule, drops, cream, injectiable, etc)
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				

Return to Jim Bowman via fax at 972-767-1432
scan or email to: jim@bowmanbenefits.com