Part D - Prescription Drug Plan Comparison Request Form

Date Completed: _____ Name: _____

Address: _____

Phone: _____

_____

County: _____

ALL information is needed to complete a personalized analysis.

Date of Birth: _____ Height: _____

Medicare ID Number: _____ Weight: _____

Effective Date Part A: _____ Smoker? Y or N

Effective Date Part B: _____ Live Alone? Y or N

	Name of Medication	Dosage Amount	Number Per Day	Medication Type
	If generic, list generic name. Exact spelling & full name of Rx is vital	*Ex: 25 mg or mcg, size of container, # in package, ml or oz?*	*Ex: 2/day or 30 pill refill lasts 3 months ** Insulin/eye drops/ inhalers-# used per monht?*	*Ex. Tablet, capsule, inhaler, etc.*
EX	Omeprazole	20 mg	1	Capsule
EX	Lantus Solostar	30 cc	3 pens/month	Injectible pen
EX	Restasis	2 drops 2x/day	.05% 1 pkg of 60/month	Eye drop
1				
2				
3				
4				
5				
6				
7				
8				

Complete Form & Return to Hoosier Benefit Plans via mail, fax or email to:

8344 Thackery Court Indianapolis, IN 46256 | Fax: 317.436.7719 | Jennifer@hoosierbenefitpans.com

Questions? Please call: 317.840.8466

Please provide a complete listing of all essential providers, including your dentist & eye care professional.

Provider First & Last Name	Specialty	Location (Street/City)
Ex) Dr. Leonard McCoy	*Primary care*	*E. 82nd. St. / Indianapolis*

Hospital(s) of Choice	Location
Dr. Leonard McCoy	*Primary care*

Current Retail Pharmacy: _____

Other questions, concerns or additional medications? _____

_____

_____

If you are not a current client, please list your current Medicare plan: _____

_____

HOOSIER Benefit Plans