



2026 PRESCRIPTION DRUG PLAN REVIEW

Tyrone Carr & Associates

Name:	Medicare ID#:	Part A Effective Date:	Part B Effective Date:
Address (please include your zip code):	Current Drug Plan & Premium Cost:	Method To Receive Your PDP Review Results: Email / Phone	
		Interested In Learning About Medicare Advantage Plans? Yes / No	
County:	What Pharmacies Do You Use?	Interested In Dental, Vision, & Hearing Coverage? Yes / No	
Home Phone:		Interested In Obtaining Quotes For Home & Auto Insurance? Yes / No	
Cell Phone:	Do You Get Your Prescriptions By Mail?	Interested In Obtaining Quotes For Life Or Final Expense Insurance? Yes / No	
Email:	Birthdate:	Interested In Learning About Financial Planning Services? Yes / No	
Spouse's Name & Birthdate:	Do You Travel Internationally?	Are You Willing To Switch Pharmacies If You Can Save Money? Yes / No	

CURRENT MEDICATION LIST

Medication Name	Generic Y/N	Dosage (example: mg)	Form (example: tablet)	Prescribed Frequency (example: 2/day)	Refill Frequency (example: 90 days)	Coupons Used (example: GoodRx) Y/N	Notes (Specify Details for Insulin & Inhaled Medications) *If frequency is left blank, "as needed" medications will be quoted for refills every 6 months.

PLEASE RETURN YOUR FORM PROMPTLY & WE WILL BEGIN CONTACTING YOU IN OCTOBER TO DISCUSS PLAN OPTIONS AND DETAILS. YOU CAN SUBMIT YOUR FORM BY MAIL, EMAIL, OR FAX.

*IF YOU NEED ASSISTANCE FILLING OUT YOUR 2026 PDP REVIEW FORM, PLEASE CONTACT OUR OFFICE AND WE WILL GLADLY ASSIST YOU.

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