2027 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 CHECK THE BOX IF YOU CURRENTLY TAKE NO MEDICATIONS ☐							

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 2027 PDP REVIEW FORM, PLEASE CONTACT OUR OFFICE AND WE WILL GLADLY ASSIST YOU.

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