

Completing this form provides information to help Everence research available Medicare Part D prescription drug plans. By signing this form, you certify that the information you’ve provided is complete and accurate and that you understand and agree to the acknowledgments below. This form can also be completed online at [everence.com/prescriptions](https://everence.com/prescriptions).

Please complete one form per person.

Name \_\_\_\_\_ Medicare Supplement Member ID \_\_\_\_\_

Address \_\_\_\_\_

Street

City

State

ZIP code

County

Phone number \_\_\_\_\_ Email address \_\_\_\_\_

Preferred pharmacy \_\_\_\_\_ Alternate pharmacy \_\_\_\_\_

Current Part D plan provider \_\_\_\_\_ Medicare Number \_\_\_\_\_

List your prescription drugs, **not including over-the-counter drugs, vitamins, herbal remedies or supplies.**

- This information is used **only** to help research available Part D prescription drug plan options.
- Use the back or an additional form if you have more prescriptions than will fit on this form.

List Only Current Prescription Medications

Drug name	Dosage	Frequency	30-day or 90-day supply

Include additional prescriptions information on the back or complete another form.

Acknowledgments

- As a complimentary service for members, Everence will help you identify and evaluate Medicare Part D Plans using Medicare’s website.
- Everence’s help with plans is based on the information you provide in this form and information on Medicare’s website. Everence does not verify this information.
- Everence will not select a plan for you; you alone are responsible for selecting a plan that’s appropriate for you.
- Everence does not issue or service Medicare Part D Plans so the company that sponsors the plan you select will service your plan.

Member Signature\_\_\_\_\_ Date\_\_\_\_\_

Please review, sign, and submit to Everence.