2020/2021 Medicare Prescriptions

16414 San Pedro Ave, Suite 665, San Antonio, TX 78232
P: 210-545-0667 F: 210-545-3766
INFO@ZINNINSURANCE.COM

Your Name:		**Date of birth:**	
Your Phone Number:		**Zip Code:**	
Name of the Pharmacy(IES) you go to:			

PLEASE FILL OUT FORM AS CLEARLY AS POSSIBLE!

Please list ALL medications that you take THROUGHOUT THE YEAR and either fax, email or mail the form back to us.

	Name of Medication ***If you are taking a generic medication, please only include the generic name****	Generic? Y / N	Dosage	Number of times a day you take the drug	How often filled 30, 60, 90 Days	Retail (R) or Mail Order (MO) Canada (C) — Please select one	Condition(s) for which meds are prescribed for?
	Please DO NOT include Over the counter Medications (OTC) and/or Vitamins.						
	If you have more medications, please make a second copy of this form!						
	If you take an RX that is "AS NEEDED" put on form. Frequency should be 12 months.						
Example	*metformin hcl tab*	*Y*	*500mg*	*1 x day*	*30, 60, 90 day*		*diabetes*
1						Retail	
2						Retail	
3						Retail	
4						Retail	
5						Retail	
6						Retail	
7						Retail	
8						Retail	
9						Retail	
10						Retail	
11						Retail	
12						Retail	
13						Retail	
14						Retail	

☐ **I DO NOT TAKE ANY PRESCRIPTION MEDICATIONS!**