# 2023/2024 Medicare Prescriptions

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| | | | |
|---|---|---|---|
| **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 upload, fax, email 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) | Condition(s) for which meds are prescribed for? |
|---|---|---|---|---|---|---|---|
| | | | | | | Please select one | |
| | 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!**