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**Information required to search for Best Medicare RX PLAN**

First Name	Last Name	First Name	Last Name		
Phone Number		Phone Number, if different			
Zip Code		Zip Code, if different			
Current Rx Plan		Current Rx Plan			
PHARMACY- PREFERENCE or MAIL-ORDER		PHARMACY- PREFERENCE or MAIL-ORDER			
ONLY LIST MEDICATIONS THAT WILL BE PURCHASED THROUGH DRUG PLAN.	<b>DON'T LIST OVER THE COUNTER MEDS</b>		IF TAKEN <b>AS NEEDED</b> PLEASE SPECIFY HOW MANY TIMES A YEAR YOU REFILL.		
Medication ( <b>EXACTLY</b> as seen on the label.)	Dosage	How often taken	Medication ( <b>EXACTLY</b> as seen on the label.)	Dosage	How often taken
*PLEASE E-MAIL, FAX OR DROP BY OFFICE, if you would like our help with your					

**RX plan.**

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