Medicare Supplements Plus INSURANCE AGENCY

Office: (903) 581-6885
Toll-Free: (888) 685-7308
Website: www.myseniorteam.com

Prescription Drug List For: _____

Pharmacy I Use: _____

Number of Medications I Currently Take: _____

What you see on your prescription drug label

What you need to enter in our drug plan questionnaire

*You will also need to let us know how often you refill your medication.

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Name of Medication:	I Take This Version of Medication:	Dosage / Strength of Medication:	My Medication Looks Like	I Take This Medication:	I Get This Medication Filled:	I Get This Quantity Per Refill:
1.	☐ Generic ☐ Brand Name		☐ tablet ☐ capsule ☐ injection pen ☐ inhaler ☐ other: _____	____ time(s) per _____	☐ Every month ☐ Every 2 months ☐ Every 3 months ☐ Every year	☐ 30 ☐ 60 ☐ 90 ☐ 120 ☐ other: _____
2.	☐ Generic ☐ Brand Name		☐ tablet ☐ capsule ☐ injection pen ☐ inhaler ☐ other: _____	____ time(s) per _____	☐ Every month ☐ Every 2 months ☐ Every 3 months ☐ Every year	☐ 30 ☐ 60 ☐ 90 ☐ 120 ☐ other: _____
3.	☐ Generic ☐ Brand Name		☐ tablet ☐ capsule ☐ injection pen ☐ inhaler ☐ other: _____	____ time(s) per _____	☐ Every month ☐ Every 2 months ☐ Every 3 months ☐ Every year	☐ 30 ☐ 60 ☐ 90 ☐ 120 ☐ other: _____
4.	☐ Generic ☐ Brand Name		☐ tablet ☐ capsule ☐ injection pen ☐ inhaler ☐ other: _____	____ time(s) per _____	☐ Every month ☐ Every 2 months ☐ Every 3 months ☐ Every year	☐ 30 ☐ 60 ☐ 90 ☐ 120 ☐ other: _____

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5.	☐ Generic ☐ Brand Name		☐ tablet ☐ capsule ☐ injection pen ☐ inhaler ☐ other: _____	____ time(s) per _____	☐ Every month ☐ Every 2 months ☐ Every 3 months ☐ Every year	☐ 30 ☐ 60 ☐ 90 ☐ 120 ☐ other: _____
6.	☐ Generic ☐ Brand Name		☐ tablet ☐ capsule ☐ injection pen ☐ inhaler ☐ other: _____	____ time(s) per _____	☐ Every month ☐ Every 2 months ☐ Every 3 months ☐ Every year	☐ 30 ☐ 60 ☐ 90 ☐ 120 ☐ other: _____
7.	☐ Generic ☐ Brand Name		☐ tablet ☐ capsule ☐ injection pen ☐ inhaler ☐ other: _____	____ time(s) per _____	☐ Every month ☐ Every 2 months ☐ Every 3 months ☐ Every year	☐ 30 ☐ 60 ☐ 90 ☐ 120 ☐ other: _____
8.	☐ Generic ☐ Brand Name		☐ tablet ☐ capsule ☐ injection pen ☐ inhaler ☐ other: _____	____ time(s) per _____	☐ Every month ☐ Every 2 months ☐ Every 3 months ☐ Every year	☐ 30 ☐ 60 ☐ 90 ☐ 120 ☐ other: _____

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10.	☐ Generic ☐ Brand Name		☐ tablet ☐ capsule ☐ injection pen ☐ inhaler ☐ other: _____	_____ time(s) per _____	☐ Every month ☐ Every 2 months ☐ Every 3 months ☐ Every year	☐ 30 ☐ 60 ☐ 90 ☐ 120 ☐ other: _____
11.	☐ Generic ☐ Brand Name		☐ tablet ☐ capsule ☐ injection pen ☐ inhaler ☐ other: _____	_____ time(s) per _____	☐ Every month ☐ Every 2 months ☐ Every 3 months ☐ Every year	☐ 30 ☐ 60 ☐ 90 ☐ 120 ☐ other: _____
12.	☐ Generic ☐ Brand Name		☐ tablet ☐ capsule ☐ injection pen ☐ inhaler ☐ other: _____	_____ time(s) per _____	☐ Every month ☐ Every 2 months ☐ Every 3 months ☐ Every year	☐ 30 ☐ 60 ☐ 90 ☐ 120 ☐ other: _____

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13.	☐ Generic ☐ Brand Name		☐ tablet ☐ capsule ☐ injection pen ☐ inhaler ☐ other: _____	_____ time(s) per _____	☐ Every month ☐ Every 2 months ☐ Every 3 months ☐ Every year	☐ 30 ☐ 60 ☐ 90 ☐ 120 ☐ other: _____
14.	☐ Generic ☐ Brand Name		☐ tablet ☐ capsule ☐ injection pen ☐ inhaler ☐ other: _____	_____ time(s) per _____	☐ Every month ☐ Every 2 months ☐ Every 3 months ☐ Every year	☐ 30 ☐ 60 ☐ 90 ☐ 120 ☐ other: _____
15.	☐ Generic ☐ Brand Name		☐ tablet ☐ capsule ☐ injection pen ☐ inhaler ☐ other: _____	_____ time(s) per _____	☐ Every month ☐ Every 2 months ☐ Every 3 months ☐ Every year	☐ 30 ☐ 60 ☐ 90 ☐ 120 ☐ other: _____
16.	☐ Generic ☐ Brand Name		☐ tablet ☐ capsule ☐ injection pen ☐ inhaler ☐ other: _____	_____ time(s) per _____	☐ Every month ☐ Every 2 months ☐ Every 3 months ☐ Every year	☐ 30 ☐ 60 ☐ 90 ☐ 120 ☐ other: _____

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18.	☐ Generic ☐ Brand Name		☐ tablet ☐ capsule ☐ injection pen ☐ inhaler ☐ other: _____	_____ time(s) per _____	☐ Every month ☐ Every 2 months ☐ Every 3 months ☐ Every year	☐ 30 ☐ 60 ☐ 90 ☐ 120 ☐ other: _____
19.	☐ Generic ☐ Brand Name		☐ tablet ☐ capsule ☐ injection pen ☐ inhaler ☐ other: _____	_____ time(s) per _____	☐ Every month ☐ Every 2 months ☐ Every 3 months ☐ Every year	☐ 30 ☐ 60 ☐ 90 ☐ 120 ☐ other: _____
20.	☐ Generic ☐ Brand Name		☐ tablet ☐ capsule ☐ injection pen ☐ inhaler ☐ other: _____	_____ time(s) per _____	☐ Every month ☐ Every 2 months ☐ Every 3 months ☐ Every year	☐ 30 ☐ 60 ☐ 90 ☐ 120 ☐ other: _____

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