In Office Use- Only Agent: _____
Name: _____
ID # _____
Date: _____

Part D Prescription Drug Plan Determination Worksheet

PLEASE UNDERSTAND THAT YOU ARE NOT REQUIRED TO PROVIDE THIS INFORMATION

Name of Medication **please copy from container** ***Please print clearly***	**Strength (mg, ml, cap, tab, pen, drop, cream, etc.)**	**How often do you take? (example: Daily, weekly or monthly)**	**Do You use** Mail Order? Y/N	**Do you use** Generic? Y/N	**How many times a year do you fill?**
Example: Ventolin HFA	*18gm inhaler*	*1 puff*	*N*	*N*	*3*
Example: Levemir flex touch	*3ml - (How many pens used in a month?)*	*Twice daily*	*N*	*N*	*12*
Example: Humalog	*3ML (Vial-How many vials used in a month?)*	*Twice daily*	*N*	*N*	*6*
Example: Atorvastatin	*20mg – Please indicate Capsules "or" Tablets*	*1-1/2 pills- twice daily*	*Y*	*Y*	*4*
Use back if needed					

Name _____ Zip code _____

Phone _____ Email _____

Current Part D Plan (please be specific):

Company Name _____ (i.e. AARP, First Health, Humana etc.…)

Plan Name _____ (i.e. Preferred Rx, Value Plus, etc.….)

Please Circle your Pharmacy: Hannaford, Rite Aid, Walgreens, Care, Walmart, other please indicate_____
OR:

Choose one of the following:

Use the VA for your medications at this time: Circle: YES or NO

I don't have a Prescription plan at this time ☐

DORAN INDEPENDENT INSURANCE, LLC PO Box 70, 64 Center Street, Wolfeboro Falls, NH 03896
Phone: 603.569.6464 Fax: 603.569.8664 www.DoranIndependentInsurance.com

Disclosure: The reports will be estimated based on the information supplied on the above worksheet.

Revised 8/2018

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