DORAN INDEPENDENT INSURANCE
Health, Life, & Long-Term Care

OFFICE USE ONLY
APPOINTMENT ☐
STAY ☐

Part D Prescription Drug Worksheet (One per person)

Name: _____

Zip code: _____

Phone: _____

Email: _____

Preferred Local Pharmacy: _____

Current Part D Plan: (Please be specific):

Company/Plan Name _____

I currently do not have a Prescription Drug Plan ☐

DISCLOSURE: The reports will be estimated based on the information supplied below.
PLEASE UNDERSTAND THAT YOU ARE NOT REQUIRED TO PROVIDE THIS INFORMATION

Name of Medication	Generic? Y/N	Strength MG, Units, ER/DR	30 day Supply?	90 day Supply?	Quantity per fill?	Mail Order? Y/N

Please contact our office with any questions.

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~ Your Trusted Time Savers ~

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