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

OFFICE USE ONLY
APPOINTMENT ☐
STAY ☐
AGENT _____

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.E. WellCare Wellness, Humana Walmart, etc.…)

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 *Please copy from container*	**Generic?** Y/N	**Dosage** Ex. Capsule, tablets, pen, vial, etc.	**Monthly Quantity?** Ex. Boxes	**Refills per year?**	**Mail Order?** Y/N

Please contact our office with any questions.

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~ Your Trusted Time Savers ~

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