



## Medicare Prescription Drug Questionnaire

Medicare Part D provides insurance coverage for your prescription drugs. Please take a few minutes to describe your current prescription drug needs. The information you provide will be used to create your personalized Medicare Part D report.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_

Email: \_\_\_\_\_

Current Part D Plan: \_\_\_\_\_

Current Medicare Health Insurance: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

**Please tell us about your current prescription drug needs:**

Preferred Pharmacy: \_\_\_\_\_

Do you use mail order? \_\_\_\_\_

Prescription Name	Strength	Dosage	Generic OK?

Please use another sheet of paper if you need more room.

**You may mail or fax your completed questionnaire to:**

VibrantUSA  
 4164 Guide Meridian, Suite 210  
 Bellingham, WA 98226

**OR** Fax #: 877-316-7688