AEP CONTACT FORM

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NAME:				
Date of Birth:				
Street Address:			**County:**	
City:		**State:**	**Zip Code:**	
Preferred #	☐	☐	☐	
Phone:	Cell:		Home:	Work:
Email:				
Current Drug Plan & Carrier:				

Do you currently have a Long Term Care policy in effect? **YES** ☐ **NO** ☐

Part A Effective Date:_____ **Part B Effective Date:**_____

PRESCRIPTIONS

** **PLEASE HELP US GET THE MOST ACCURATE INFORMATION FOR YOU.** Use estimated amounts per month for creams, ointments, liquids and "As Needed" scripts. Also, unless specified, we will select the generic version of your drug, rather than brand.**

NAME	DOSE	FREQUENCY	GENERIC	BRAND
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

Preferred Pharmacy _____

For Office use only: SF____ E____ S____ D____ D2SS_____ PDF_____