**<INSERT YOUR AGENCY LOGO HERE>**

Dear Consumer,

You recently requested assistance from <Your agency name here> for a Medicare Part D Plan comparison. To ensure your personalized results, please complete the information on the enclosed form titled “List of Medications and Dosages” *or* provide us with a **current** drug list from your pharmacy and return to:

<YOUR AGENCY NAME & ADDRESS HERE>

The tool used to do the plan comparison is the Medicare Health and Drug Plan Finder located at [www.medicare.gov](http://www.medicare.gov/). Using your drug list and your choice of pharmacies, the plan finder will sort all available plans and provide important cost estimates and coverage information.

We will provide you with a detailed summary of the top three plans based on the cost and coverage of your specific medications. Your printed results summary will be mailed to you at the address you provide on the Part D form.

The information in the Medicare Prescription Drug Plan Finder Chart is not always 100% accurate. **Prescription drug pricing fluctuates throughout the year and the prices reflected are not a guarantee.** We recommend you contact the plans to verify the accuracy of the information prior to enrollment. Contact information is provided on the plan summary.

The <Your Agency Name Here> is your source of unbiased information. We are not affiliated with any insurance company. If you have questions, please call <YOUR AGENCY PHONE NUMBER>.

Thank you.

<YOUR NAME/AGENCY>

**List of Medications and Dosages**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**Medicare #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Part A begin Date: \_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Preferred Pharmacy: (1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **(2)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **(3)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Would you consider a Mail Order Pharmacy? \_\_\_\_\_\_YES \_\_\_\_\_\_NO**

**Current Plan Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please check type: ( ) Medicare Advantage Plan ( ) Part D plan only (PDP)**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Prescription Drug Name** | **Dosage** (mg, mcg, ml, vial, tube) | **Pills / month** (number per day X 30) |
| 1 |  |  |  |
| 2 |  |  |  |
| 3 |  |  |  |
| 4 |  |  |  |
| 5 |  |  |  |
| 6 |  |  |  |
| 7 |  |  |  |
| 8 |  |  |  |
| 9 |  |  |  |
| 10 |  |  |  |
| 11 |  |  |  |
| 12 |  |  |  |
| 13 |  |  |  |
| 14 |  |  |  |
| 15 |  |  |  |