# **Medicare Part D** – Quote Request Form

Name: Email Address:

Address:

City: State: Zip Code:

Preferred Pharmacy:

| **NAME OF DRUG** | **DOSAGE**<br>*Prescribed strength or amount administered at prescribed intervals.* | **QUANTITY**<br>*The amount of medication you receive each time you refill a prescription.* | **FREQUENCY**<br>*How often you refill your prescription.* | **PHARMACY TYPE**<br>*The type of pharmacy you get your medicine from. For example, a mail order pharmacy or retail pharmacy.* |
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