

Kitchie McBride, MHA - Health Insurance Services

Medications & Providers

Name: _____ Date: _____

NOTE: Please send this as an attachment via secure messaging at

<https://kitchiemcbride.com/km-his>

What is your current health plan coverage?

- ☐ Marketplace: STATE _____
- ☐ Employer Group Health Plan
- ☐ Medicare
- ☐ Medicaid
- ☐ Tricare
- ☐ Other _____
- ☐ I don't know



Medication Name	Dosage Ex. 50 mg 10 mcg	Quantity Ex. One tablet	Frequency Ex. 2x a day	Supply Length Ex. 30, 60, or 90 days

Provider Name	Specialty (PCP/ Specialist/ Dentists)	Phone	Address

Pharmacy Name _____ Pharmacy Address _____