

For Office Use Only: Plan name: \_\_\_\_\_  
Appointment time and date: \_\_\_\_\_

MAPD  
CIF Received: \_\_\_\_\_  
SOA Received: \_\_\_\_\_

**One form per person**

**Name:** \_\_\_\_\_ **County:** \_\_\_\_\_

**Address (street, city, zip):** \_\_\_\_\_

**Primary Phone:** \_\_\_\_\_ **Email Address:** \_\_\_\_\_

### **Pharmacy Information**

Do you use Mail Order to fill your prescriptions? \_\_\_\_\_

When you pick up prescriptions, which pharmacy do you use? Please include address. \_\_\_\_\_

### **List of Medications** (Please only list PRESCRIPTION Medications you fill at the pharmacy.)

<b>Drug Name (as listed on bottle)</b>	<b>Tablet or Capsule</b>	<b>Dosage (mg)</b>	<b># per day</b>	<b>30- or 90-day script?</b>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

### **List of Doctors** on back



**Hardey Senior Consulting**

Nicole Hardey  
Licensed Independent Broker  
636.462.2701

Please **MAIL** completed form to Hardey Senior Consulting,  
240 Magee Street, UPS Store Mailbox #312, Troy, MO 63379

Or **E-MAIL** to [nicole@hscllc.us](mailto:nicole@hscllc.us)

Or **FAX** to 636.628.2677

We do not offer every plan available in your area. Currently we represent 7 organizations, which offer 128 products in Missouri. Please contact Medicare.gov, 1-800-MEDICARE, or your local State Health Insurance Program (SHIP) to get information on all of your options. We are not affiliated with or endorsed by any governmental agency. By responding to this letter, I understand a sales agent may contact me by telephone, email, or mail to discuss Medicare Advantage and Prescription Drug plans, and Medicare Supplement Insurance Plans.

*(If you have printed this form from an e-mail, please include your name above.)*

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