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

PDP or MAPD
CIF Received: _____
SOA Received: _____

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***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.)

| ***Drug Name (as listed on bottle)*** | ***Dosage (mg)*** | ***# per day*** | ***30- or 90-day script?*** |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
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| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

***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

*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.*

Name: _____

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

***List of Medications*** (Please only list PRESCRIPTION medications you fill at the pharmacy.) **Continued from front.**

| ***Drug Name (as listed on bottle)*** | ***Dosage (mg)*** | ***# per day*** | ***30- or 90-day script?*** |
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## *List of Doctors including dental & vision*

| **Doctor's Full Name** | **Specialty** | **Office street address <u>and</u> zip code** |
|---|---|---|
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