

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

PDP
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.)

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

Please add additional medications on the back, if needed.



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@hscilc.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.