

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

MAPD | PDP

One form per person

Name: _____

Address (street, city, zip): _____ **County:** _____

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.)

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

List of Doctors on back



Julie Myers
Licensed Independent Broker
636.489.2770

Please **MAIL** completed form to My Tri-County Benefits,
404 E Main Street, Warrenton, MO 63383

Or **UPLOAD** to: <https://mytricitybenefitsllc.sharefile.com/r-r397bc7cd8dd8419b8177371550e453a2>

Or **FAX** to 636.489.2770

Not affiliated with or endorsed by any governmental agency. Your information will be provided to a licensed insurance agent. You may be contacted by a licensed insurance agent. We do not offer every plan available in your area. Currently, we represent 9 organizations which offer 133 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.

