

2024 STANDALONE DRUG PLAN REVIEW FORM

Enrollment Starts October 15, 2023

IMPORTANT: Medicare Open Enrollment Ends: December 7, 2023

NAME: _____ PHONE: _____

STREET: _____ CITY/STATE/ZIP: _____

EMAIL: _____ DATE OF BIRTH: _____

YOUR PHARMACY: _____ YOUR CURRENT DRUG PLAN: _____

LIST OF MEDICATIONS

Please fill out the list of your current medications including: Name, dosage (mg), Number of Times Taken Per Day in order to get the drug review. Completing this form will not prevent you from enrolling into any plan of your choice for which you are eligible.

NAME OF MEDICATION	BRAND	GENERIC	DOSAGE (MG)	NUMBER OF TIMES TAKEN
	<input type="checkbox"/>	<input type="checkbox"/>		____ Per Day/Month/Year (Circle)
	<input type="checkbox"/>	<input type="checkbox"/>		____ Per Day/Month/Year (Circle)
	<input type="checkbox"/>	<input type="checkbox"/>		____ Per Day/Month/Year (Circle)
	<input type="checkbox"/>	<input type="checkbox"/>		____ Per Day/Month/Year (Circle)
	<input type="checkbox"/>	<input type="checkbox"/>		____ Per Day/Month/Year (Circle)
	<input type="checkbox"/>	<input type="checkbox"/>		____ Per Day/Month/Year (Circle)
	<input type="checkbox"/>	<input type="checkbox"/>		____ Per Day/Month/Year (Circle)
	<input type="checkbox"/>	<input type="checkbox"/>		____ Per Day/Month/Year (Circle)
	<input type="checkbox"/>	<input type="checkbox"/>		____ Per Day/Month/Year (Circle)
	<input type="checkbox"/>	<input type="checkbox"/>		____ Per Day/Month/Year (Circle)
	<input type="checkbox"/>	<input type="checkbox"/>		____ Per Day/Month/Year (Circle)

Please mail, email or fax this form to Elizabeth Vipond
Email: Betsy@TheSeniorHealthAdvisor.com
Phone: 1-800-603-0901 | Fax: 1-813-443-1292
Please Note: Your form will be forwarded to Dan Downs,
Dan@DrugstoreUnlimited.com | 813-381-5220



The **SeniorHealth**Advisor

Phone: 1-800-603-0901 | Fax: 1-813-443-1292

Please note that your information is held in private and all data is uniformly secured in accordance with the standards set forth in the Health Insurance Portability and Accountability Act.

STATEMENT AND REQUEST FOR CONTACT

I am making the express request for contact by my agent Elizabeth Vipond and/or Dan Downs for their services in reviewing all plans available to me and do not wish to be limited to a review of my current plan.

PRINT NAME: _____

SIGNATURE: _____ **DATE:** _____

**Please return this form by fax at 813-443-1292 or email it to:
Betsy@theseniorhealthadvisor.com. You can also mail your response to:
Elizabeth Vipond, 1209 E. Cumberland Ave. Unit 1903, Tampa, FL 33602.**

**There are no fees associated with this review. Compensation is based
on your plan enrollment.**



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