2020 PART D REVIEW REQUEST

FRANK INSURANCE GROUP LLC

Name: _____

Phone: _____ Email Address: _____

Zip Code: _____ Best Time to Reach Me: _____

Current Part D Company: _____ Current Medicare plan or Supplement: _____

Preferred Pharmacy: _____ Date of Birth: _____

Do you have Senior Care? ❑ Yes ❑ No

Annual household income ((optional-to check if you qualify for help): $ _____

If you have one, please provide your ***My Medicare*** account information:

Username: _____

Password: _____

FOR MORE INFORMATION ABOUT CREATING YOUR MY MEDICARE ACCOUNT **CLICK HERE**

Please use the worksheet below to provide us with a list of your current medications.

NAME OF MEDICATION	DOSAGE	FREQUENCY	HOW OFTEN IS THE PRESCRIPTION FILLED?
EXAMPLE: Simvastatin Tablets	20 mg	Once a day	90 pills every 3 months
EXAMPLE: Humalog 50/50 Kwikpens	3mL Pen	50 Units per day	Pkg of 5 pens lasts 1 month

SCAN AND EMAIL COMPLETED REQUEST FORM TO: ***AL@FRANKINSURANCEWI.COM***
OR Mail completed request form to:

Frank Insurance Group LLC
7818 Big Sky Dr Ste 204
Madison, WI 53719

We will reach out to you with our recommendation after we have had a chance to review.