

Medication List

Please have this list returned to Fred Pries & Leslie Jones Insurance via mail PO Box 190 Winchester, email lesliejonesinsurance@gmail.com, or dropped off at the office 111 S. Main Street, Winchester by November 15 for prompt processing. We must also have a complete Scope of Appointment form 48 hours prior to any appointments. The annual election period for Part D & Part C is from Oct 15th to Dec 7th. Using your medication list we will run a personalized prescription analysis report to help you determine the prescription drug plan that best suits your needs and saves you the most money. We are happy to serve you and thank you for your continued business. Sincerely, Leslie Jones

Name:	Phone Number:
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Email Address:

Address:

Preferred Pharmacy:

Current Plan:	Monthly Cost \$
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Do you have an insulin pump: Y or N	Are you a transplant recipient? Y or N
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How often do you fill your medications (please circle): 30 days 60 days 90 days other:
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Medication (as listed on bottle)	Dose	Frequency (If med is "as needed" please estimate a specific amount.)	If medication is a bottle, vial, tube, or pen please note in this column specifically the size and how many you receive each time medication is filled.
Example: Lisinopril	10mg tablet	daily	

If additional spaces are needed please use back or attach additional pages using the above information.