EIWSPD Rxform 2017

We Shop Part D, Inc.
Medicare Part D Report Request Form

Full Name ______________________________ *(Please use one sheet per person)*

City __________________ County __________ State ________ Zip _________

Phone ______________________________ Email _____________________________

1. Do you have Medicare Part A? ☐ Yes ☐ No
2. Do you fill prescriptions through the Veteran's Administration (VA)? ☐ Yes ☐ No
3. Name of Current Pharmacy : ____________________________
4. Current D plan Carrier and plan name: ____
5. List your prescription details below (exclude all Over-the-Counter drugs):

	Medication Name	***Dosage***	***Frequency***
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			

Please write any additional medications on the back of this form.

***To determine your report cost, please check the box listing the number of prescriptions you entered above.**

☐ 1 - 5 Medications $75 ☐ 6 - 10 Medications $100 ☐ 11+ Medications $125

☐ Please send a copy of this report to my insurance agent below:

Name: ______________________ Phone: ______________ Email: ___________________________

Who referred you to our site? ____

IMPORTANT: Please enclose a check or money order (amount shown above) with your order form in the enclosed envelope or submit your information online with a credit card at: www.WeShopPartD.com Checks should be payable to We Shop Part D, Inc.

Mailing address **:** We Shop Part D, Inc.
3832-010 Baymeadows Rd, Ste 197
Jacksonville, FL 32217