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

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

Address_____

City _____County_____ State _____ Zip _____

Phone _____ Email _____

1 Do you have Medicare Part A and B? ☐ Yes ☐ No

2 Do you fill prescriptions through the Veteran's Administration (VA)' ☐ Yes ☐ No

3 Name of Preferred Pharmacy : _____

4 Current D plan (carrier and name): _____

5 List your prescription details below (exclude all Over-the-Counter drugs):

	Medication Name *(exactly as appears on label)*	***Is generic equivalent ok? If so, mark box with an X***	**Dosage** *(i.e., mg, mcg, gm, vial, tube)*	**Frequency** *(1/day, 1/week, PRN)*	**Refill Frequency** *(each month, every 6 months)*
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 cost, please select the box matching 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:** _____

IMPORTANT: Please enclose a check or money order (amount shown above) made payable to We Shop Part D, Inc with your order form and mail to:

We Shop Part D, Inc.
3832-010 Baymeadows Road Suite 197
Jacksonville, FL 32217

OR submit information online at www.WeShopPartD.com and receive a 10% discount.
Use coupon code: WSPDGNC