ALLIED INSURANCE ADVISORS, LLC

MEDICARE DRUG & DOCTOR LIST

Medicare website ID #_____ **Date**_____ **(Agent Use Only)**

Name:_____ **Date of Birth:**_____

Zip Code:_____ **County:**_____

PRESCRIPTION DRUG LIST

Prescription Name (indicate any letters after name)	Dosage ____	Frequency____	Generic	Brand
1)_____	_____	_____	☐	☐
2)_____	_____	_____	☐	☐
3)_____	_____	_____	☐	☐
4)_____	_____	_____	☐	☐
5)_____	_____	_____	☐	☐
6)_____	_____	_____	☐	☐

PREFFERED PHARMACY INFORMATION

Pharmacy Name & Address:_____

DOCTOR LIST

Please list your primary care doctor as well as any other physicians or specialists

Doctor Name (First & Last)_____	Primary or Specialist____	City_____	Zip Code_
1)_____	_____	_____	_____
2)_____	_____	_____	_____
3)_____	_____	_____	_____
4)_____	_____	_____	_____

NOTES:

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***** Please fax to 678-546-7372 or email to charles@aia-planning.com *****