

Medicare Part D Prescription Drug Worksheet

Name: _____ Best Contact Phone Number: _____

Address: _____ City: _____ Zip: _____

County: _____ Email: _____

Prescription Drug list:

Name of Drug	Dosage	Quantity per month	If available, will you use generic?

Name of your Current Plan that covers your drug costs? _____

Do you have a preferred pharmacy? _____ If yes, which pharmacy? _____

Please return to:
Kentucky Health Solutions
2365 Harrodsburg Rd . Ste B235
Lexington, KY 40504