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 by either format:

Email: Pete.Alberti@kyhealthsolutions.com
Fax: 859-963-1243

Mail to: Kentucky Health Solutions
P.O. Box 24801
Lexington, KY 40524