MEDICARE INFORMATION FORM

Name: _____

Address: _____

_____

Phone: _____

County: _____

E-mail address: (optional) _____

Do we have permission to contact you by e-mail? Yes ____ No ____

Primary Care Physician: _____

Specialists you are an established patient with:

_____

_____

_____

_____

My Pharmacy: _____

Prescription medications you take:

Name		**Dosage**	**How often you take**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

This form may also be found on-line at www.medicarebenefitsnc.com

Form may be mailed back to us or scanned and e-mailed to *mcleodinsurancellc@gmail.com*

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