2505 W. Franklin Blvd.
Gastonia, NC 28052

Sheffield
INSURANCE AGENCY

www.sheffieldins.com
(704) 671-4779

Medicare Prescription Drug List

PLEASE PRINT CLEARLY

Email: _____@_____

Client Name: _____ Phone: _____ Zip Code: _____

Please **PRINT** the **ENTIRE** prescription drug name as printed on the bottle. **LIST THEM IN ALPHABETICAL ORDER.** If the drug is generic, please print the entire generic name.

	Name (as printed on bottle)	Dosage Amount and Type	Pill Amount per day	Pill Amount per month
Ex	*Atorvastatin Calcium*	*20 Mg - Tablet*	*1*	*30*
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				

Your Preferred Pharmacy: _____

Your **Primary Care** Physician: _____

Your **Specialist** Physician(s): _____

_____

Your Current Insurance Coverage: _____

Insurance Coverage You are Interested in: _____