Prescription and Physician Update Form For Medicare Plan Annual Review

Electronic submission option available online at: http://www.citizenadvisory.com/medicareforms

Return completed form to jim@citizenadvisory.com OR Citizen Advisory Group Attn: Jim Poling
770 Commerce Dr., Perrysburg, OH 43551

Client Name: _____

Preferred Phone Number/Email: _____

Your Preferred Pharmacy(s): _____

Please be as specific as possible with the Rx information. If you are taking a Generic medication list the Generic name. You do not need to list OTC medications.

	Name of Medication	Dosage	Frequency Taken
1)	_____	_____	_____
2)	_____	_____	_____
3)	_____	_____	_____
4)	_____	_____	_____
5)	_____	_____	_____
6)	_____	_____	_____
7)	_____	_____	_____
8)	_____	_____	_____

Primary Care Physician (full name): _____

Specialists (full name): 1)_____ 2)_____

3)_____ 4)_____

5)_____ 6)_____

Preferred Hospital(s): _____

Want to Change Your Plan (Yes/No) Why? _____

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