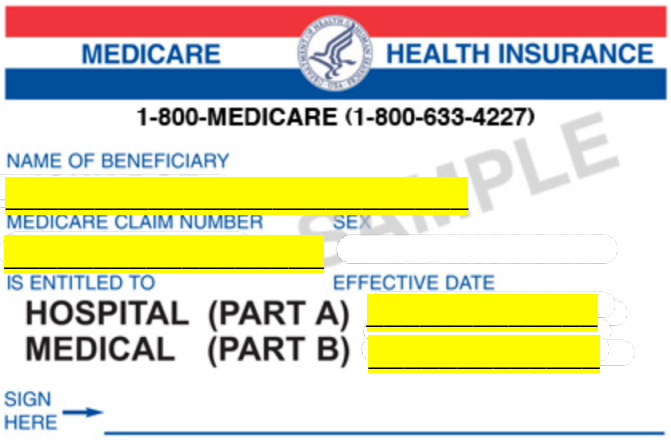
MEDICARE.GOV Prescription Drug Plan (PDP) Quote Request Form

If you would like us to run your PDP options for 2019 via the Medicare.gov site, please complete this form in full and return to us via fax to: 866-625-6856 or by email: team@princetonhrsolutions.com, or send to us secure by saving and then clicking here: PHRS Secure File Upload.

Client Name:	
Address:	
Phone:	
Email Address:	
County:	
2 pharmacies where you would fill Rxs:	1) 2)

Rx Name	Generic OK?	Dose	Type	Frequency	Fill Preference
Enter the **FULL NAME** of your Rx, making sure it is spelled **CORRECTLY**	Indicate YES if you are ok with taking a generic version if available	Ex. "10 mg" or "0.25 ml"	(ex: capsule or tablet? Vial? Injection? Cream?)	How often do you take/use this Rx (ex: 1x/day, 2x/day, 1x/week)	How often and where you fill your Rxs (for example: 1x/month at pharmacy or '1x every 3 months via mail order')
	YES __				
	YES __				
	YES __				
	YES __				
	YES __				
	YES __				
	YES __				
	YES __				
	YES __				
	YES __				

If you have more Rxs to list, please use the back of this page or complete another copy of this form



If you wish for our office to assist with this, please complete/return the above to us by 9/28/18