Instructions to Patient/Caregiver :

Please complete this form and bring it to your Walgreens Pharmacy to receive a FREE report of Medicare Prescription Insurance Plans or Drug Discount Cards available in your area of residence OR to see if you qualify for extra financial help with your prescription insurance costs.

Please Note: This is NOT an application for enrollment in a Medicare Prescription Plan or Other Drug Discount Card.

PATIENT INFORMATION:

Name (First, M.I., Last):

Primary Phone Number: **Birth Date (mm/dd/yyyy):**

Address:

City, State, ZIP Code:

MEDICATION INFORMATION:

Please list the medication names you would like us to include in our search. (Please use the back of this page for more room.)

ADDITIONAL INFORMATION:

Please Note: This information is only required if you are requesting a Drug Discount Card report.

1. Does the patient currently have any of the following? (Check only those that apply)

☐ **Prescription coverage through Employer or Spouse's Employer**

☐ **Government assistance program**

☐ **Disability Benefits**

2. Is the patient currently single or married? ☐ **Single** ☐ **Married**

3. What is the patient's annual household income? $ ☐ **No Response**

4. What are the patient's combined savings, investments, and property (excluding his or her home)? $ ☐ **No Response**