DRUG LIST

I authorize Tracy Thomas CSA, an agent with Sovereign Seniors LLC, to call me regarding my coverage options and understand that I am volunteering this prescription drug information.

Name: _____

Signature: _____ Date: _____

Phone Number: _____ Pharmacy: _____

Important Instructions: Please complete this entire form. Do not include over the counter medicines or vitamins and write the ENTIRE name of your drug exactly how it appears on the bottle.

DRUG NAME	Strength	Taken Daily?	# per day	Capsule or Tablet?
Example: Bupropion SR Tab	40 mg	Y	1	Tablet
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				

Write additional medications on the back and check this box [ ]

INSULIN DRUGS ONLY *(Enter information EXACTLY as noted. Units/dosages will not help.)*	Bottles or Pens?	# Bottles/Pens per Month
Example: Levemir	Pen	12
1.		
2.		
3.		

Return this list and your completed Scope of Appointment to:

Mail: Sovereign Seniors LLC
119 Evergreen Rd. #43311
Louisville, KY 40243
Attn: Tracy Thomas, CSA

Fax to: (502) 333-0511
Phone: (502) 215-0881