



2027 MEDICARE PRESCRIPTION REVIEW

Please complete this form and return via mail, email, or fax

MAIL TO: HighRoad Partners
209 NP Ave N
Fargo, ND 58102

EMAIL: info@highroadpartners.com

FAX: 701-212-1192

PHONE: 701-997-3734

NAME:			
TELEPHONE #:		ZIP CODE:	
COUNTY:		PREFERRED PHARMACY:	
PHARMACY LOCATION:		USE DIFFERENT PHARMACY IF REDUCES PRESCRIPTION COSTS?	

OPTION 1: Attach your MyChart or pharmacy drug list.

OPTION 2: Complete medication tracker below, use extra pages as needed.

MEDICATION TRACKER				
NAME OF MEDICATION:	TYPE: TABLET, CAPSULE	DOSE / STRENGTH:	QUANTITY PER MONTH:	REFILL FREQUENCY: EX. MO, 90 DAYS, 6MOS

IMPORTANT ACKNOWLEDGMENT

HighRoad Partners will compare Medicare prescription drug plans using the information you provide. You are responsible for providing complete and accurate medication and pharmacy information; incomplete or inaccurate information may affect the results. Plan costs, formularies, pharmacy networks and coverage are determined by the insurance carrier and may change.

Our review is intended to assist you in comparing plans; the final plan selection is yours. Many Medicare plans now require beneficiaries to complete their own enrollment and do not permit HighRoad Partners to enroll on their behalf. Unless HighRoad Partners confirms in writing that we will assist with your enrollment, you are responsible for completing your own enrollment by the applicable Medicare deadline.

SIGNATURE: _____ DATE: _____