Medicare D Plan Form

Please fill out the following form and send to Guardian Pharmacy by October 5th, 2018. The following form MUST BE completed in FULL before being submitted to the pharmacy.

Open Enrollment is October 15, 2018-December 7th, 2018.

Resident's Name:_____

Date of Birth:_____

Resident's Zip Code: _____

Facility Name: _____

Medicare Number (send a copy): _____

Effective Date (when resident became eligible): _____Month _____Year

Other Rx Coverage Cards (Optional):_____

Please make a copy of the following and send along with this form:

- ☐ Medicare Card
- ☐ Other Rx Coverage Cards (Optional)
- ☐ Medication List

We will print the 3 best options for the resident's medications and mail it to the address below, by November 10, 2018. Should you have any questions once received please call our billing department at 912-764-7839, Option #4.

Name:_____

Address:_____

Phone Number:_____

Relationship to Resident:_____

Once the above is completed please mail info to haley.anderson@guardianpharmacy.net or fax to 866.534.5566, Attention Haley, No later than October 5th.