DRUG LIST

I authorize an agent with Imagine Insurance Advisors to call me regarding my coverage options and understand that I am volunteering this prescription medication 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 medication exactly how it appears on the bottle.

MEDICATION 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: Imagine Insurance Advisors
3036 Breckenridge Ln Ste 101
Louisville, KY 40220

Fax to: (502) 749-7700
Email to: AMHarris@ImagineInsAdv.com
Phone: (502) 742-4979

Office use only. Do not complete information below.

Drug ID Number : _____ Date: _____ 2019