Prescription Analysis Form

The purpose of this form is to provide you with a comprehensive analysis of your estimated copays and out-of-pocket costs with the current prescriptions you are taking. This form is **optional**.
If you would like us to review your prescriptions, please provide the information below and return **prior** to **FRIDAY, NOVEMBER 15TH** by email (info@insurehelena.com), mail (931 North Last Chance Gulch, Helena, MT 59601), or fax (888-437-6292). These analyses are completed on a first in-first out basis, so you do **NOT need an appointment**. Please call our office at (406) 457-1243 with any questions or concerns. Thank you!

NAME: _____ PHONE: _____

RESIDENTIAL ZIPCODE: _____ COUNTY: _____

DO YOU USE MAIL ORDER? YES ☐ NO ☐ CURRENT PLAN: _____

PREFERRED PHARMACY: _____ I DO NOT TAKE ANY PRESCRIPTIONS ☐

*PLEASE DO **NOT** INCLUDE THE FOLLOWING:
Over-the-counter Medications, Vitamins, Supplements, and Injections you receive from your doctor.

PRESCRIPTION NAME	DOSAGE	FORM	HOW MANY IN A REFILL?	HOW OFTEN DO YOU REFILL?
Example Drug 1	30 mg	Tablet	30 tablets	30 days
Example Drug 2	5 ml	Vial	12 vials	6 months

OFFICE USE ONLY:
AGENT: _____ APPOINTMENT: _____ SOA: _____