Action for Older Persons

200 Plaza Drive, Suite B
Vestal, NY 13850

HIICAP
Health Insurance Information, Counseling & Assistance

Name _____
Address _____
City _____ State _____ Zip _____
County _____ Phone _____

RETURN TO ACTION FOR OLDER PERSONS AT LEAST 7 DAYS BEFORE APPOINTMENT:

- **Email: aoprxlist@gmail.com**
- **Fax: 607-722-1293**
- **Mail: 200 Plaza Drive, Suite B Vestal, NY 13850**
- **Drop off at our office**

	Name of Prescription Medication (NOT over the counter, supplements, vitamins etc.)	**Generic** (yes or no)	**Dosage** (mg)	**Frequency** (how many per day)	**30 or 90 day supply**
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

More space for prescriptions on back

- **Do you receive Medicaid? ____ Yes ____ No**
- **Do you get Extra Help paying for your medication through Social Security? ____ Yes ____No**
  IF YES : Full_____ or Partial_____
- **Is your Part B premium paid for by a Medicare Savings Program? ____ Yes ____No**
- **Pharmacies where you prefer to shop:**
  _____ Location: _____
  _____ Location: _____

Office use only:

ID: _____
APPT. DATE: _____ TIME: _____

	Name of Prescription Medication (NOT over the counter, supplements, vitamins etc.)	**Generic** (yes or no)	**Dosage** (mg)	**Frequency** (how many per day)	**30 or 90 day supply**
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					
25					

Additional Comments:

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