RBR Benefit Services
Employee Benefits & Medicare Plans

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Client Pharmaceutical List

CLIENT NAME: _____ **ID#.** _____ **DATE:** _____

PLAN NAME: _____ **ZIP CODE:** _____

CURRENT PHARMACY: _____

Please fill out (PRINT) the required drug information and scan this form to rhonda@rbrbenefitservices.com as a **PDF file** attachment. This form is for **PRESCRIPTION DRUGS ONLY.** Do not include over-the-counter medications.

DRUG NUMBER - Line number of drug taken.
MEDICINE NAME - The name of your drug.
DOSAGES - The prescribed strength or amount of therapeutic ingredient(s) administered at prescribed intervals.
QUANTITY - The amount of medication you receive each time you refill a prescription.
FREQUENCY - How often you refill your prescription.

DRUG #	MEDICINE NAME	DOSAGES	QUANTITY	FREQUENCY	PHARMACY TYPE
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					