Please complete and bring along to your meeting, or if doing a phone or video meeting, return PRIOR to your meeting. You can also send a copy of your own list as long as all the information is included. Email to your broker, drop off, mail or fax.

Heidi - hwhittaker@sholleyagency.com John - jmoser@sholleyagency.com Fax: 570-523-1833

Name: _____

Prescription Name (as it appears on your medication)	Dosage (ex. 10 mg, 2/day)	30 Day Supply	90 Day Supply	Take Regularly	Take "As Needed" (PRN)

Please Reply to Each Statement:	Answer Yes or No
I use a mail order pharmacy.	
I use a retail pharmacy.	
Name of my preferred Pharmacy	

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