REQUEST FOR REVIEW OF COVERAGE

I request The Stonum Agency to use the following information to review my current coverage.

If this form is not complete, I will be unable to review your plan.

****HOW WOULD YOU LIKE YOUR REVIEW RESULTS SHARED WITH YOU???****
__✔__ IN-OFFICE APPT. __✔__ TELEPHONE APPT.

_____ _____
(YOUR SIGNATURE) (TODAY'S DATE)

_____ _____
(ZIP CODE & COUNTY) (BIRTHDATE)

HOSPITAL OF CHOICE: _____ PRIMARY CARE DOCTOR: _____

SPECIALISTS: (FIRST & LAST NAME) _____

_____

PHARMACY YOU ARE CURRENTLY USING/PREFER: _____

LIST YOUR CURRENT PRESCRIPTIONS BELOW:

NAME OF PRESCRIPTION (Capsule or tablet or %)	DOSAGE (MG) BOTTLE(ML) TUBE (GM)	HOW MANY DO YOU TAKE PER DAY?	30 OR 90 DAY SUPPLY?

Disclaimer: The Stonum Agency will not sell, license, transmit or disclose this information outside of the Company unless (a) expressly authorized by you, (b) necessary to enable the Company's agents to perform certain functions for us, or (c) required or permitted by law. In all cases, we will disclose the information consistent with applicable laws and regulations and we will require the recipient to protect the information and use it only for the purpose it was provided.

FOR OFFICE USE ONLY

MAPD/PDP current:	Updated:
MAPD/PDP upcoming:	Broker: