WOOTEN
AGENCY

2024 Plan Information Request Form

Please choose only ONE of these options to submit your information.

1. Fill out both sides of this form and send back to us in the envelope provided.
2. Fill out, scan, and email both sides of this form to **cedwooten@gmail.com**
3. Visit our website at **www.wootenagency.com/renewal** to submit online.

DEADLINE FOR SUBMITTING YOUR LIST IS NOVEMBER 9.

Name: _____ **Phone:** _____

Address: _____

ZIP Code: _____ **County:** _____

Would you like your results by email? ☐ Yes ☐ No

Email: _____

Current Plan (from your ID Card): _____

Primary Care Physician: _____

Specialists: _____

What is your preferred pharmacy? _____

Do you receive your prescriptions by mail? ☐ Yes ☐ No

Would you be willing to change pharmacies to lower your cost? ☐ Yes ☐ No

If you receive a Low-Income Subsidy (Extra Help) for your Part D plan, please select:

☐ Full Extra Help ☐ Partial Extra Help

Additional Comments: _____

_____

_____

_____

150 Iowa Lane, Suite 104, Cary, NC 27511 | **cedwooten@gmail.com**

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Instructions: Please print clearly the entire name as printed on the prescription bottle. If the drug is generic please print the entire generic name.
For insulin, please list how many pens/vials used per month. For pills, please specify if Capsule, Tablet or Caplet. Let us know how often you fill each prescription.

	Drug Name *(Generic or brand name; as printed on bottle.)*	Dosage Amount and Type *(Capsule, Tablet, Caplet)*	How Many Pills Per Day?	How Often Do You Refill? *(30, 60, or 90 Days)*
E.g.	*Levothyroxine*	*0.05 Mg – tablet*	*1*	*30*
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				

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