PRESCRIPTION ANALYSIS FORM

*The purpose of this form is to provide you with a comprehensive analysis of your estimated copays and out-of-pocket costs with the current prescriptions you are taking. This form is **optional**.*
*If you would like us to review your prescriptions, please provide the information below and return **prior** to **FRIDAY, NOVEMBER 15TH** by email (info@insurehelena.com), mail (931 N. Last Chance Gulch, Helena, MT 59601), or fax (888-437-6292). These analyses are completed on a first in-first out basis, so you **do NOT need an appointment**. Please call our office at (406) 457-1243 with any questions or concerns. Thank you!*

---

*Please print your information clearly:

NAME: ____ PHONE: ___________________________

RESIDENTIAL ZIPCODE: _______________________ COUNTY: _________________________________

DO YOU USE MAIL ORDER? (Circle one) YES NO CURRENT PLAN: ___________________________

WHICH PHARMACY DO YOU USE? ____________________________________ I DO NOT TAKE ANY PRESCRIPTIONS ☐

---

*PLEASE DO **NOT** INCLUDE THE FOLLOWING:

- Over-the-Counter medications, Vitamins, Supplements, and Injections you receive from your doctor.

Prescription Name	**Dosage** (200mg, mcg, ml, etc)	**Form** (tablet, vial, capsule)	**How many in a refill?**	**How often do you refill?** (per day/mon/yr)
EXAMPLE DRUG 1	30 mg	Tablet	30 tablets	30 days
EXAMPLE DRUG 2	5 ml	Vial	12 vials	6 months

OFFICE USE ONLY:
Agent: ___________________________ Appointment: _____________________________ SOA:___