My Prescription Drug List

Date: _____

Your Name: _____

Phone: _____

Zip Code and County: _____

Your preferred pharmacy: _____

Do you use a mail order pharmacy? _____

Do you qualify for extra help? (ie: Medicaid, Missouri RX) _____

Current Part D Insurance plan (if known): _____

DFG INSURANCE

417.889.7700

Name of Medication *Do not include OTC*	Dosage (mg, mcg)	How Often? (per day/month)

Notes:

How to return this form

Fax to: 417.889.7708

Email to: info@myDFGinsurance.com

Drop off or **Mail to**:

DFG Insurance
1550 E. Battlefield Road Suite K
Springfield MO 65804