Current Medication List

Your Name:_____ **Date**:_____

Complete Drug Name from Bottle/Container	**Dosage / Container Size** See list below	**Form** See list below	**Quantity Per Refill**	**Refill Frequency** See list below	**Generic OK** (Y)es or (N)o	**Using GoodRx*** (Y)es or (N)o
EXAMPLES						
Metoprolol Succinate ER	50mg	Tab	90	Q	Y	N
Albuterol Sulfate HFA	90mcg/8.5g	Inhaler	1	M	Y	Y

FORM: Tab Cap Inhaler Drops Patch Injection Vial Lotion Cream Ointment Gel

DOSAGE/SIZE: Be sure to list BOTH dosage and container size for Inhalers, Drops, Lotions, Creams, Ointments and Gels

REFILL FREQUENCY: (M)onthly (Q)uarterly (SA)Semi-Annually (A)nnually (BM)Every 2 months

DO NOT list "AS NEEDED" – Complete Refill Frequency with one of the above options

*Answer (Y)es if using GoodRx or any other discount drug plan to fill medication

Return form to HealthCare Benefit Services
Mail: 6638 W. Ottawa Ave, Suite 120, Littleton, CO 80128
Fax: 720-287-7055, Email: info@HBSLTC.com (Email is not a secure form of communication.)
Phone: 303-973-6636 or **800-295-5860**