HILL'S DRUG STORE, INC.

BENEFICIARY INFORMATION SHEET

BENEFICIARY INFORMATION

Last Name: First Name: Middle Initial:

Date of Birth: Social Security Number: Sex:

Marital Status: Phone Number: Cell Number:

Address:

City: State: Zip:

Place of Residence:
(i.e.Beneficiary Home, Caregiver, LTC, SNF, w/Family)

Emergency Contact Person: Contact Number:

Caregiver's Name: Caregiver's Phone Number:

PHYSICIAN INFORMATION

Physician's Name:

Address: City: State: Zip:

Office Phone: Date of Last Office Visit:

INSURANCE INFORMATION

Medicare Number: Part B Effective Date:

Name of Secondary Insurance: Phone:

Policy or ID Number: Group Number:

Name of Policyholder (if other than Beneficiary):

Beneficiary Relationship to Policyholder:

Policyholder's Date of Birth: Policyholder's Social Security Number:

Employer's Name: Employer's Address:

City: State: Zip:

I understand that this form is vital in processing Beneficiary Medicare prescrptions and will remain confidential.

Beneficiary or Caregiver's Signature Date

Beneficiary or Caregiver's Printed Name