MEDICATION COST ESTIMATE

Personal Information	
Name:	**Daytime Phone:** ( ) -
Mailing Address:	**Last 4 Digits of SSN:** ___ ___ ___ ___
Plan Name:	**Birthday** Month/Day/Year: __ __ / __ __ / __ __

Name of Medication	Dosage	How Many Times a Day
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Return Information:

By Mail: SERS, Attn: Health Care, 300 E. Broad St., Suite 100, Columbus, Ohio, 43215-3746
By Fax: 1-614-340-1820
By Email: healthcare@ohsers.org

You may receive a return call from Know Your Rx pharmacist on behalf of SERS. Please take the call.

HCS-7080 5/2024