



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.

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