



Medication Voucher Program

Prescription Form

Name (print)		Gender	Date of Birth
Address		Telephone Number	
City	State	Zip Code	

- Are you currently a resident of the state of Iowa? Yes No
- I do **NOT** have insurance coverage for Prescription Drugs. Yes No
- Are you currently enrolled in a Medicare Part D program? Yes No
- If “yes” to the above, are you currently in the donut hole in coverage? Yes No
- Do you have transportation available to travel to a participating pharmacy? Yes No

Signature of Applicant or Representative _____
Date

By my signature, I certify that all information on this form is accurate and complete. I understand the Iowa Prescription Drug Corporation may contact me in the future to verify this information. If the information I have provided is incomplete or inaccurate, and I do not meet the eligibility requirements any services I request may be denied.

Patient Information

Name: _____

Medication - Prescription, Over-the-counter, Herbal	Strength	Quantity Per Day

Are you allergic to any medications?

Yes No

If yes please list: _____

List any major medical conditions: _____

Name of Physician: _____

Phone: _____