PM FORM 3.1.1

TRACKING OF MEDICARE PART D ENROLLMENT

Recipient		Case Manager, Clinical Liaison or Primary Point of Contact		Client Information System (CIS)	Recipient on AHCCCS (dual)	Part D Plan		
Last Name	First Name	Name	Phone number	Recipient ID #	[Y/N]	Name	PDP, MA-PD, or MA-PD/SNP	Effective Date

Revised: 03/15/2006