< *Optional: Insert MTM provider/plan logo* >

< *Optional: Insert MTM provider/plan logo* >

< *Insert letter date* >

< *Insert member name* >
< *Insert member address 1* >
< *Insert member address 2* >
< *Insert member city, state, and zip code* >

< *Additional space for optional plan/provider use, such as barcodes, document reference numbers, beneficiary identifiers, case numbers or title of document* >

Dear < *Insert member name* >,

Thank you for talking with me on < *Insert CMR date* >, about your health and medications. As a follow-up to our conversation, I have included two documents:

1. Your **Recommended To-Do List** has steps you should take to get the best results from your medications.

2. Your **Medication List** will help you keep track of your medications and how to take them.

If you want to talk about these documents, please call < *Insert MTM provider/department name* > at < *Insert contact information for MTM provider/plan, phone number, days/times, TTY, etc.* >.

I look forward to working with you and your doctors to make sure your medications work well for you.

Sincerely,

< *Insert MTM provider name* >
< *Insert MTM provider title*>, < *Insert Part D plan/pharmacy name/organization name* >

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB number for this information collection is 0938-1154. The time required to complete this information collection is estimated to average 40 minutes per response, including the time to review instructions, searching existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850

Recommended To-Do List

Prepared on: < *Insert CMR date* >

You can get the best results from your medications by completing the items on this **"To-Do List."**

Bring your **To-Do List** when you go to your doctor. And, share it with your family or caregivers.

My To-Do List

What we talked about:	**What I should do:**
< Insert summary of discussion for topic 1 >	❑ *< Insert action item for topic 1 >* ❑ *< Insert action item for topic 1 >*

What we talked about:	**What I should do:**
< Insert summary of discussion for topic 2 >	❑ *< Insert action item for topic 2 >* ❑ *< Insert action item for topic 2 >*

What we talked about:	**What I should do:**
< Insert summary of discussion for topic 3 >	❑ *< Insert action item for topic 3 >* ❑ *< Insert action item for topic 3 >*

What we talked about:	**What I should do:**
< Insert summary of discussion for topic 4 >	❑ *< Insert action item for topic 4 >* ❑ *< Insert action item for topic 4 >*

How to Safely Dispose of Unused Prescription Medications

Prepared on: < *Insert CMR date* >

Medication List

Prepared on: < *Insert CMR date* >

Bring your Medication List when you go to the doctor, hospital, or emergency room. And, share it with your family or caregivers.

Note any changes to how you take your medications.
Cross out medications when you no longer use them.

Medication	**How I take it**	**Why I use it**	**Prescriber**
< Insert generic name and brand name, strength, and dosage form for current/active medications >	*< Insert regimen, (e.g., 1 tablet by mouth daily), use of related devices, and supplemental instructions as appropriate >*	*< Insert indication or intended medical use >*	*< Insert prescriber name >*

Add new medications, over-the-counter drugs, herbals, vitamins, or minerals in the blank rows below.

Medication	How I take it	Why I use it	Prescriber

Allergies:

< *Insert allergy information* >

Side effects I have had:

< *Insert side effect information* >

Other information:

< *Optional* >

My notes and questions: