

< MTM PROVIDER HEADER or
OPTIONAL LOGO >

< MTM PROVIDER HEADER or
OPTIONAL LOGO >

< Insert date >

< Insert inside address >

< Insert salutation >:

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

Thank you for talking with me on < insert date of service > about your health and medications. Medicare's MTM (Medication Therapy Management) program helps you understand your medications and use them safely.

This letter includes an action plan (Medication Action Plan) and medication list (Personal Medication List). **The action plan has steps you should take to help you get the best results from your medications. The medication list will help you keep track of your medications and how to use them the right way.**

- Have your action plan and medication list with you when you talk with your doctors, pharmacists, and other healthcare providers in your care team.
- Ask your doctors, pharmacists, and other healthcare providers to update the action plan and medication list at every visit.
- Take your medication list with you if you go to the hospital or emergency room.
- Give a copy of the action plan and medication list to your family or caregivers.

If you want to talk about this letter or any of the papers with it, please call <insert contact information for MTM provider, phone number, days/times, TTY, etc. >. < I/We > look forward to working with you, your doctors, and other healthcare providers to help you stay healthy through the < insert name of Part D Plan > MTM program.

< Insert closing, MTM provider signature, name, title, enclosure notations, etc. >

MEDICATION ACTION PLAN FOR < Insert Member's name, DOB: mm/dd/yyyy >

This action plan will help you get the best results from your medications if you:

1. Read “What we talked about.”
2. Take the steps listed in the “What I need to do” boxes.
3. Fill in “What I did and when I did it.”
4. Fill in “My follow-up plan” and “Questions I want to ask.”

Have this action plan with you when you talk with your doctors, pharmacists, and other healthcare providers in your care team. Share this with your family or caregivers too.

DATE PREPARED: < INSERT DATE >

What we talked about: < Insert description of topic >	
What I need to do: < Insert recommendations for beneficiary activities >	What I did and when I did it: < Leave blank for beneficiary's notes >

What we talked about:	
What I need to do:	What I did and when I did it:

What we talked about:	
What I need to do:	What I did and when I did it:

What we talked about:	
What I need to do:	What I did and when I did it:

What we talked about:	
What I need to do:	What I did and when I did it:

My follow-up plan (add notes about next steps):
< Leave blank for beneficiary's notes >

Questions I want to ask (include topics about medications or therapy):
< Leave blank for beneficiary's notes >

If you have any questions about your action plan, call *< insert MTM provider contact information, phone number, days/times, etc. >*.