MSSP Participant's Medications Including: Nonprescription Medications, Vitamins, and Minerals

Participant's Last Name	First Name	MI	MSSP #

Date	Medication	Dosage	#/ Freq Taken	Doctor	Covered By Medicare? Yes or No

MSSP Staff: _____ Date: _____

(Optional) Sent for Review to Doctor(s)_____ Date: _____