



## Medicare Part D Program Solicitation

**Fax To:** (262) 335-6221  
Clint Gehring  
Provider Relations Specialist  
RESTAT  
724 Elm Street  
West Bend, WI 53095  
(800) 926-5858

We wish to enroll in your program as a provider for Medicare Part D.

This is the following information about our pharmacy:

=====

Pharmacy Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

Email Address: \_\_\_\_\_

NABP#: \_\_\_\_\_

Medicare Provider #: \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(Print)

Title : \_\_\_\_\_

Signature: \_\_\_\_\_