Medicare Resource Center

How did you hear about us?______________________ **Appointment Scheduled:** ____/____/____ **Appointment Scheduled:** ____/____/____

Client Name: First ____ **Last** ____ **MI**________

Date of Birth________/________/__________ M____ F____ **Nickname:** ___________________________ **Are you a Veteran?** ☐ Yes ☐ No

Medicare #: ____ **Social Security #:**____

Part A Eff: ________________________ **Part B Eff:** _________________________ **Spouse:** ____

Phone H: ____ **Phone C:** ____

Street:____

City: ___________________________________**State:**_________ **Zip:** ________________ **County:** ____________________________________

Email: ____

Current Medicare Plan Name: ____ **Monthly Premium:** ___________________

Current Medicare Plan Carrier: ☐ UHC ☐ Anthem ☐ Aetna ☐ Humana ☐ MedMutual
☐ Allwell ☐ MediGold ☐ Meridian ☐ Bright Health ☐ Other_____________________

Do you have Medicaid? ☐ Yes ☐ No **Do you have Extra Help?** ☐ Yes ☐ No **Do you need Dental/Vision/Hearing?** ☐ Yes ☐ No

Primary Care Physician (PCP)____ Phone: ____

Address:____

UHC PCP #____Anthem PCP #____

Aetna PCP #____Humana PCP #____

MedMutual PCP #____Wellcare PCP #____

Other PCP info:____

Specialist ____ ☐ UHC ☐ Anthem ☐ Aetna ☐ Humana ☐ MMO ☐ Wellcare ☐ MediGold

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Specialist ____ ☐ UHC ☐ Anthem ☐ Aetna ☐ Humana ☐ MMO ☐ Wellcare ☐ MediGold

Eye Doctor ____ ☐ UHC ☐ Anthem ☐ Aetna ☐ Humana ☐ MMO ☐ Wellcare ☐ MediGold

Dentist____ ☐ UHC ☐ Anthem ☐ Aetna ☐ Humana ☐ MMO ☐ Wellcare ☐ MediGold

Notes:____

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Rx List Preferred Pharmacy____________________

____________________ Dosage__________ Quantity__________

____________________ Dosage__________ Quantity__________

____________________ Dosage__________ Quantity__________

____________________ Dosage__________ Quantity__________

____________________ Dosage__________ Quantity__________

____________________ Dosage__________ Quantity__________

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____________________ Dosage__________ Quantity__________

____________________ Dosage__________ Quantity__________

____________________ Dosage__________ Quantity__________

Part D Carrier/Plan Options	Monthly/Quarterly Premium		Monthly/Quarterly Drug Costs		Monthly/Quarterly Totals
		+		=	
		+		=	
		+		=	

MONTHLY COSTS

Part A Cost:__________

Part B Cost:__________ IRMAA: __________

Part D Cost: __________IRMAA: __________ Payment Method: __________

MAPD Cost: __________Supplement Cost: __________Payment Method: __________

FOR OFFICIAL USE:

Medicare Plan Chosen: ____________________ Effective Date: _____/_____/_____

Confirmation #____________________ Date Enrolled: _____/_____/_____

PDP Plan Chosen: ____________________ Effective Date: _____/_____/_____

Confirmation #____________________ Date Enrolled: _____/_____/_____

Medicare.gov info:____________________

Applied for Extra Help? ☐ Yes ☐ No Level:__________Re-Entry #:__________Date: _____/_____/_____

Notes:____________________