Medicare Needs Analysis

Section 1

Name		**Date of Birth**	
Street			
City	**State**	**Zip**	**County**
Phone		**Email**	

Section 2

Do you currently have Medicare Part A or Part B?

Part A **Part B** **Neither**

Part A/B Effective Date (If applicable)	**Medicare ID #**

Do you currently receive Medicaid or extra help?

Yes **No**

List of Current Prescriptions

Drug Name (Generic/Brand)	Dosage in Milligrams (MG)	Tablet or Capsules	Quantity per Month

Drug Name (Generic/Brand)	**Dosage in Milligrams** (MG)	**Tablet or Capsules**	**Tablet or Capsules**

What do you like about your current plan?

Is there a monthly budget you'd like to stay within?

Section 3

Do you have End Stage Renal Disease (ESRD) and/or Amyotrophic Lateral Sclerosis (ALS)?

Yes **No**

Select plans offer special coverage for certain medical conditions. Do you have any other existing conditions such as diabetes, heart disease, or COPD?

Yes **No** **If so, what?**

Do you receive any injections/treatments at a clinic or hospital?

Yes **No**

If yes, what are they? Please describe.

Are you willing to look at health plan options that do not include your current provider(s)?			
Yes	No		
If not, please list your doctors and their locations.			
Please list your pharmacy and it's location.			
Do you live in a long-term care or skilled nursing facility? Yes No			
Do you live part-time in another state? Yes No			
If yes, how many months of the year? 3 months 6 months 9 months			
Are there any extras you would like in your plan if possible?			
Gym membership	Transportation	Over-the-counter benefits	Dental/vision
Additional Info:			