Medicare Needs Analysis

Date	Name	Date of Birth

Address	City	State	Zip Code

Zip Code on record with Social Security (If different from above)	

Primary Phone	Email Address

Do you receive medicaid or extra help (lis) with prescription costs? ☐ Yes ☐ No

Medicare Effective Dates: Part A _____ Part B _____

Do you have a Medicare Advantage Plan or Supplement Plan? ☐ Yes ☐ No

If yes, what is the name of the plan?	Effective Date

Do you have VA benefits? ☐ Yes ☐ No

Prescription Drugs	Dosage	Frequency
1.		times per
2.		times per
3.		times per
4.		times per
5.		times per
6.		times per
7.		times per
8.		times per

	Doctor Name	Name of Practice	Practice Address
Primary			
Specialist			
Specialist			
Specialist			

Preferred Pharmacy	City

<Agent Name>

<Agent Phone>
<Agent Email>
<Agent Website>

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Medicare Needs Analysis (Optional)

Are you in good health or do you have chronic conditions like Diabetes or CHF?

Do you have ESRD? (End Stage Renal Disease) ☐ Yes ☐ No

How would you feel about seeing a new doctor or doctors?

How much do you travel and where?

Do you travel internationally? ☐ Yes ☐ No

Do you reside in more than one state or country? ☐ Yes ☐ No

If yes, where? _____

Are you eligible for any health care coverage besides medicare? ☐ Yes ☐ No

If yes, will you keep that coverage when you retire? ☐ Yes ☐ No

Approximately how much did you spend on health care last year? _____

Do you expect similar costs this year or this upcoming year? _____

Last Year		This Year or Upcoming Year	
Insurance Premiums $	Out-of-Pocket Costs $	Insurance Premiums $	Out-of-Pocket Costs $

What benefits are most important to you in a plan? (Hospital, Doctor Copays, Dental, Durable Medical Equipment, Etc.)

What do you like best about your current coverage?

What would you like to improve in a potential new plan?

Do you have any other concerns?