Medicare Intake Form

Client Info

First Name | **Middle Initial** | **Last Name**

Address | **City** | **State** | **Zip Code**

Email | **Phone #**

Date of Birth (/ /)

Medicare #

Gender

Male ◯ **Female** ◯

Part A Effective (/ /)

Part B Effective (/ /)

Provider Info

Primary Care Physician

First Name | Last Name | PCP ID

Specialist

First Name | Last Name | Specialty

List other facilities (hospitals, clinics, & urgent care) that you would like covered by your plan

Name | Type | Address

Medication Info

What pharmacy do you currently use?

Name | Address

Do you belong to a State Pharmaceutical Assistance Program (SPAP) like 'New York EPIC' or 'New Jersey PAAD'?

Yes ◯ **No** ◯

Medicare Intake Form (cont.)

Medication Info (cont.)

List any prescription medication you require

Medication	Dosage	Amount	Frequency

Additional Info

Desired Coverage (Medicare Supplement, Medicare Advantage, Prescription Drug)

Are You US Citizen? Yes ◯ No ◯

Are You Veteran? Yes ◯ No ◯

Do you receive Medicaid benefits from the state? Yes ◯ No ◯

Do you live in another state more than 6 months out of the year? Yes ◯ No ◯

Check any chronic conditions that apply to you:

- ☐ Alcohol Abuse
- ☐ Drug Abuse/ Substance Abuse
- ☐ Alzheimer's Disease and Related Dementia
- ☐ Heart Failure
- ☐ Arthritis (Osteoarthritis and Rheumatoid)
- ☐ Hepatitis (Chronic Viral B & C)
- ☐ Asthma
- ☐ HIV/AIDS
- ☐ Atrial Fibrillation
- ☐ Hyperlipidemia (High cholesterol)
- ☐ Autism Spectrum Disorders
- ☐ Hypertension (High blood pressure)
- ☐ Cancer (Breast, Colorectal, Lung, and Prostate)
- ☐ Ischemic Heart Disease
- ☐ Chronic Kidney Disease
- ☐ Osteoporosis
- ☐ Chronic Obstructive Pulmonary Disease
- ☐ Schizophrenia and Other Psychotic Disorders
- ☐ Depression
- ☐ Stroke
- ☐ Diabetes
- ☐ Other

If other, please specify.

We do not offer every plan available in your area. Any information we provide is limited to those plans we do offer in your area. Please contact Medicare.gov or 1-800-MEDICARE to get information on all of your options.