

 **This form *must be completed & returned* before your appointment.**

Medicare Claim # _____ - _____ - _____

(Found on your Medicare Card)

Part A (Effective date) _____ - _____ - _____

Part B (Effective date) _____ - _____ - _____

This information
will be kept
completely
CONFIDENTIAL

First Name Middle Name Last Name

Current Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Date of Birth _____

Mailing Address if different

Street Address _____

City _____ State _____ Zip _____

1. Do you currently have Medicare Part D coverage?

Y N

If yes, what plan? _____

2. Do you have any other prescription insurance?

Y N

If yes, which one? _____

3. Do you have health insurance?

Y N

If yes, what plan? _____

4. Do you have a pharmacy preference?

Y N

If yes, which pharmacy? _____

5. Are you interested in mail order?

Y N

6. How do you want to pay for your Medicare Part D Plan premium?

Auto withdrawal from *Social Security*

Auto withdrawal from *Bank*

Pay by check directly to plan

7. Are you a resident of a long term care facility?

Y N

