MEDICARE QUESTIONNAIRE

(SINGLE or MARRIED, EACH SPOUSE TO COMPLETE A SEPARATE FORM)

This form is extremely important. Your accuracy and completeness in responding will help me represent you. Bring this form and requested documents with you to our appointment!

Date: _____ File No.: _____

A. CLIENT DATA

Full Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____

Cell Phone: _____ Fax: _____

Email Address: _____

Birth Date: _____ Social Security Number: _____

Address where claimant resides: _____

Do you have employer sponsored drug coverage? O Yes O No

If yes, please be sure to provide a copy of your insurance card.

Are you a Veteran? O Yes O No

Are you enrolled in Tricare? O Yes O No

If you are/were married, was your spouse a Veteran? O Yes O No

Are you enrolled in PACE/PACE NET? O Yes O No

If no, please provide a copy of your last year's income tax return.

B. MEDICARE INFORMATION (from your Medicare card):

Effective Date of Enrollment: Part A (Hospital): _____

Effective Date of Enrollment: Part B (Medical): _____

Please bring your Medicare card, all insurance cards, and all prescription cards to your appointment!

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C. YOUR PREFERRED PHARMACY:

Name: _____Phone Number: _____

Location: _____

D. YOUR MEDICATIONS:

In order to gather this information, you may choose to visit your pharmacy and ask for a print-out of your current prescriptions. Otherwise, you should fill out the chart completely with all your current prescriptions!

NAME OF DRUG (Generic or Drug Name)	DOSAGE (Ex. 10mg)	QUANTITY/Month (Ex. 1 per day = 30)	FREQUENCY OF PRESCRIPTION
			O Monthly O Bi-Monthly
			O Monthly O Bi-Monthly
			O Monthly O Bi-Monthly
			O Monthly O Bi-Monthly
			O Monthly O Bi-Monthly
			O Monthly O Bi-Monthly
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