Customer Information

Name: ___________________________________ DOB: ________
Phone: ____________________ Cell: ______________________
Email: ____
Medicare Number: _______________________________________
Part A: Date: ____________ Part B: Date: ____________
Do you have: Part D: ____ Dental: ____ Gym: ____ Vision: ____
Medicaid Number: _______________________________________
Status: Active ____ Inactive ____ Last Certified Date: _______

Perm Home Address: _____________________________________
____
County: ____

Secondary Home Address: _________________________________
____
County: ____

Current Medicare Policy:
____
____

What do you like about your current plan:
____
____

What would you like to change about your current plan:
____
____

What else do you have in addition to your Medicare:
____
____

Do you have Tricare for Life? ____ Tricare for Life Number:
____

What Hospitals do you use:

____

____

What Prescriptions do you take:

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Prim. Care Dr: ______________________________ Code:_________
Specialist ___________________________________ Code:_________
Specialist ___________________________________ Code:_________
Specialist ___________________________________ Code:_________
Specialist ___________________________________ Code:_________
Specialist ___________________________________ Code:_________

Do you travel: ____________ How often: ______________________

Where: ____

New Plan Preference: ______________________________________

____

Why this new plan: ____

____

Other Info: ____

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