Medicare Needs Analysis Worksheet

NORTH AMERICAN INSURANCE SERVICES

Name: _____ **Cell:** _____ **Hm:** _____

Address: _____ **City:** _____ **State:** _____

Zip Code: ____ **DOB:** ____ **SS#** _____ **Part A** _____ **Part B** _____ **Medicare#** _____

Current Health Plan: _____ **Current Drug Plan:** _____

Other drug coverage like VA, retirement plan etc.: _____

Preferred Pharmacy: _____ **Do you use mail order?** ____ **Yes** ____ **No**

Current PCP: _____ **Current Specialist:** _____ **Hospital:** _____

Which is most important: ____ **Doctor** ____ **Specialist** ____ **Hospital**

Current Dental Plan: _____ **Current Vision Plan:** _____

Is transportation provided in your current plan: ____ **Yes** ____ **No**

Is a gym membership provided in your current plan: ____ **Yes** ____ **No** **Name?** _____

Do you have Chronic Conditions ____ **Asthma** ____ **COPD** ____ **Cardiovascular Disease CVD)** ____ **Congestive Heart Failure (CFH)** ____ **Dementia** ____ **Diabetes** ____ **Hypertension**

Would you like information on Low Income Subsidy to assist with the cost of your prescriptions (up to $4,000 per year may be available)? ____ **Yes** ____ **No**

1. Did you lose/drop employer coverage in the last 63 days? ..... ___ Yes ___ No
2. Do you have full or partial Medicaid? ..... ___ Yes ___ No
3. Have you recently lost full or partial Medicaid? ..... ___ Yes ___ No
4. Are you receiving assistance paying for your prescription drugs (LIS)? ..... ___ Yes ___ No
5. Have you lost assistance paying for your prescription drugs (LIS)? ..... ___ Yes ___ No
6. Have you moved to a county in the last 63 days? ..... ___ Yes ___ No
7. Do you have a chronic illness (COPD, Diabetes, etc.?) ..... ___ Yes ___ No
8. Is your health plan non renewing, terminating or leaving the service area?..... ___ Yes ___ No
9. Have you recently moved in or out LTC or Skilled Nursing Facility? ..... ___ Yes ___ No
10. Have you or will you be voluntarily losing your health coverage? ..... ___ Yes ___ No
11. Has your health plan contract terminated? ..... ___ Yes ___ No
12. Recently gained/lost state pharmaceutical assistance program (SPAP)?..... ___ Yes ___ No
13. When you turned 65 did you enroll in a MA/MAPD plan? ..... ___ Yes ___ No
14. Did you drop a Medigap plan to enroll in a MA plan for the first time and are you still in your trial period?..... ___ Yes ___ No
15. Are you enrolling in a CMS 5-Star related MAPD or PDP plan? ..... ___ Yes ___ No

***** If a client answered yes to any of these questions, they may be eligible for a Special Enrollment Period***

CHECK DOCTORS?

PHYSICIAN	#	TYPE	PHONE #	ADDRESS	PHCS	NOTES

CONDITIONS & MEDICATIONS?

CONDITIONS	#	MEDICATIONS	MG	PER DAY	DATE PRESCRIBED	DATE DISCONTINUED

ADDITIONAL INFORMATION: Please provide details for any of the following within the past 5 years: ***Pregnant, cancer, heart attack, stroke, advised to have surgery, drug/alcohol abuse, DWI, hospitalizations, medications for past conditions, implants/internal fixations, or counseling.***

_____

_____

_____

Pharmacy: _____ Hospital:_____ Dentist:_____ Mothers Madian Name:_____

Bank:_____ Name on Account:_____ Bank Routing #_____ Account #_____