



CMBROKER MEDICARE FACT FINDER (OVER 65)

NAME: _____ **DOB:** _____

ADRESS: _____

_____ **Zip Code:** _____ **County:** _____

Phone #: _____ **(ALT Phone #)** _____

Email: _____ **How would you like to be contacted** ____ **Email** ____ **Text** ____ **call**

Medicare Questions: Please, answer these questions to better assess your current situation so we can recommend the best Plan for you. Thank You.

Do you currently have a Medicare Advantage Plan or a Supplement? ____ **NO** **If yes, with whom?**

How much is your Monthly Premium? _____

What benefits do you like or not like about your plan? _____

Do you have Medicare Part A and B? ____ **YES,** ____ **NO**

Part A effective date: _____ **Part B effective date:** _____

Do you have a Part D (Prescription Drug Plan)? ____ **YES,** ____ **NO**

Do you receive Medicaid or Extra Help for Prescription Medications? ____ **YES,** ____ **NO**

Are you currently on any Medications? (Name, Dosage, Frequency Filled)

Do you have a primary care Doctor or specialist that you see so, we can make sure they are in network?

What Pharmacy do you use? _____

When would you like to schedule an appointment to follow up? _____

Please, write any additional Medications or other information on the back if needed.