



CMBROKER MEDICARE FACT FINDER (OVER 65)

NAME: _____

DOB: _____

ADDRESS: _____

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.