NAME: _____ COUNTY:_____

MEDICARE ANALYSIS FORM

Please list all your doctors so we can make sure they are all in network for your analysis. Use the blank space below to list all your doctors.

1. Please double check the spelling as a single wrong letter will kick it out of the system
2. Please include FIRST and LAST name
3. If you see a nurse practitioner, they will often NOT come up in provider look ups. If this is the case we need one of the main MDs listed in the practice as all physicians and NP's typically fall under the same insurance umbrella of the clinic.

Primary Care Physician:

Specialist 1:

Specialist 2:

Specialist 3:

Specialist 4:

Specialist 5:

Specialist 6:

Specialist 7:

PART D - Prescription Drug Plan Analysis

Please list all medications you are currently taking or will need to take for the foreseeable future so we can do a proper cost analysis for you. We typically don't worry about short term meds you are no longer needing (sinus infection, etc)

	Medication Name	
	Dosage and Frequency	
	Diagnosis/Medical Condition	
	Date Originally Prescribed	

	Medication Name	
	Dosage and Frequency	
	Diagnosis/Medical Condition	
	Date Originally Prescribed	

	Medication Name	
	Dosage and Frequency	
	Diagnosis/Medical Condition	
	Date Originally Prescribed	

	Medication Name	
	Dosage and Frequency	
	Diagnosis/Medical Condition	
	Date Originally Prescribed	

What are you top 3 local pharmacies in order of preference?

Do you like to Mail Order your prescriptions? YES / NO

NAME: _____

DATE OF BIRTH: _____

PHONE #: _____

EMAIL: _____