Medicare Planning Worksheet

YOUR BASIC INFORMATION

Name:_____
Date of Birth:_____
Address: _____
Phone: _____
Email: _____

If you have questions completing the worksheet, call us at 734-206-1882

Mail completed worksheet to:
7431 Jackman Rd.
Temperance, MI 48182

Or email to: AEP@rudolphins.com

CURRENT MEDICAL PROVIDERS

Doctor's Name	Specialties	Address	Phone Number
	Primary Care		

PREFERRED MEDICAL FACILITIES

Facility Name	Facility Type	Address	Phone Number
	Blood Lab		
	Machine Test (MRI, CT, X-ray)		
	Walk-in Clinic		
	Hospital		

PRESCRIPTION DRUG LIST **WHAT IS YOUR PREFERRED PHARMACY_____**

Prescription Name	Generic (if available)	Dosage	Quantity	Frequency 30, 60, 90 days
	☐ **Yes** ☐ **No**			
	☐ **Yes** ☐ **No**			
	☐ **Yes** ☐ **No**			
	☐ **Yes** ☐ **No**			
	☐ **Yes** ☐ **No**			
	☐ **Yes** ☐ **No**			
	☐ **Yes** ☐ **No**			
	☐ **Yes** ☐ **No**			
	☐ **Yes** ☐ **No**			

Do you qualify for Extra Help? also known as Part D Low Income Subsidy (LIS)? Y / N