MEDICARE –Information Collection Sheets

DATE_____DOB_____AGE_____

CELL#_____HOME#_____

Office_____

LEGAL NAME_____

ADDRESS_____

City _____STATE_____ZIP_____

COUNTY_____

EMAIL_____

FAX: 863-588-1596

Email: Sue@InsAdvocates.com or Lynne@InsAdvocates.com

TRUSTED MEDICARE ADVOCATES

863-588-1615

On Medicare Now_____

Collecting SS yet: _____

SMOKER: _____

ON DISABILITY: _____

Red/White & Blue *MEDICARE* CARD INFO

MEDICARE #_____

PART A *effective* DATE_____

PART B *effective* DATE_____

SS#_____

Born in (City/State)_____

Coming off of a Plan:

MEDICARE PLAN YES NO

INDIVIDUAL PLAN YES NO

EMPLOYER PLAN: YES NO

more than 20 ees YES NO

Current Employer Plan Insurance ***CARRIER NAME***:_____

Type of Plan: __PPO__ POS__EPO/HMO

How much are you paying/contributing to this plan: $_____

EMPLOYER NAME_____

Phone #_____

ID#_____

Group#_____

Effective Date _____

ANY OTHER MEDICAL SITUATIONS WE SHOULD BE AWARE OF?

_____

_____

_____

_____

_____

***NOTE**: Please let me know if you have been admitted into hospital as in inpatient within the past 90 days? Do you have end stage renal disease? Are you currently receiving dialysis? Diagnosed with Kidney Disease that may require dialysis? Had organ transplant, back or spine surgery, joint replacement, surgery for heart, vascular or cancer.*

Who Referred you: _____

Medicare charges for Part B (additional income related portion -**IRMAA**) MONTHLY amount below; BILLED quarterly or taken out of your SS if you are collecting. Part B amount is based on the MAGI (modified adjusted gross income)

***2023 MAGI= Adjusted Gross Income (form 1040 line 11) + Tax-Exempt Interest (form 1040 line 2a)**

CHECK OFF YOUR TIER	INDIVIDUAL RETURN ADJUSTED GROSS INCOME	JOINT RETURN ADJUSTED GROSS INCOME	MEDICARE **PART B COST**	**MEDICARE PART D COST** Additional for Rx	Combined MEDICARE **PART B COST**
___**1**	$106k or less	$212k or less	$185.00	*none*	$185.00
___**2**	$106,001 to $133k	$212,001 to $266k	$259.00	$13.70	$272.70
___**3**	$133,001 to $167k	$266,001 to $334k	$370.00	$35.30	$405.30
___**4**	$167,001 to $200k	$334,001 to $400k	$480.90	$57.00	$537.90
___**5**	$200,001 to $500k	$400,001 to $750k	$591.90	$78.60	$670.50
___**6**	Greater than $500k	Greater than $750k	$628.90	$85.80	$714.70

2025 RATES DISPLAYED – MED SUP PLAN G IS NOW $257 DEDUCTIBLE FOR PART B EXPENSES

OTHER NOTES

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PRIMARY *Care Doctor*_____

*Phone Number*_____

*Address*_____

*City*_____*STATE*_____*ZIP*_____

SPECIALIST *Doctor*_____

*Phone Number*_____

*Address*_____

*City*_____*STATE*_____*ZIP*_____

SPECIALIST *Doctor*_____

*Phone Number*_____

*Address*_____

*City*_____*STATE* NJ _____*ZIP*_____

Prescription Drug Plan Search

Please use an additional sheet of paper if necessary.

Client Name: _____ **Current Drug Coverage:** _____

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

Preferred Pharmacy(s) First: _____ Second: _____

Does your client prefer mail-order prescriptions? ☐ Yes ☐ No

How often does the client prefer to fill their prescription(s)? ☐ 30 days ☐ 90 days ☐ Other _____

Drug Name	Can the generic be taken? (if applicable)	Drug Format Type (tab, cap, cream, patch, vial, pen, etc)	Dosage	Quantity	Frequency Drug Needs Taken
	☐ Yes ☐ No				
	☐ Yes ☐ No				
	☐ Yes ☐ No				
	☐ Yes ☐ No				
	☐ Yes ☐ No				
	☐ Yes ☐ No				
	☐ Yes ☐ No				
	☐ Yes ☐ No				
	☐ Yes ☐ No				
	☐ Yes ☐ No				
	☐ Yes ☐ No				
	☐ Yes ☐ No				
	☐ Yes ☐ No				
	☐ Yes ☐ No				
	☐ Yes ☐ No				
	☐ Yes ☐ No				
	☐ Yes ☐ No				
	☐ Yes ☐ No				
	☐ Yes ☐ No				

FOR AGENT USE ONLY

Drug List Source: _____ **Drug List ID/Quote #:** _____ **Drug Quote Date:** _____

(Medicare.gov or other drug-pricing tool) *(Medicare.gov uses as password)*