

MEDICARE –Information Collection Sheets

PAGE 1 of 3

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) _____

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.

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 _____

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)

***2024 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
<u>1</u>	109k or less	\$218k or less	\$206.50	none	\$206.50
<u>2</u>	\$109,001 to \$137k	\$218,001 to \$274k	\$289.10	\$14.50	\$303.60
<u>3</u>	\$137,001 to \$171k	\$274,001 to \$342k	\$413.00	\$37.50	\$450.50
<u>4</u>	\$171,001 to \$205k	\$342,001 to \$410k	\$536.90	\$60.40	\$597.30
<u>5</u>	\$205,001 to \$500k	\$400,001 to \$750k	\$660.80	\$83.30	\$744.10
<u>6</u>	Greater than \$500k	Greater than \$750k	\$702.10	\$91.00	\$793.10

2026 RATES DISPLAYED – MED SUP PLAN G IS NOW \$288 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 _____ 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				
	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)