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)

***2022 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**	103k or less	$206k or less	$174.70	*none*	$174.70
___**2**	$103,001 to $129k	$206,001 to $258k	$244.60	$12.90	$257.50
___**3**	$129,001 to $161k	$258,001 to $322k	$349.40	$33.30	$382.70
___**4**	$161,001 to $193k	$322,001 to $386k	$454.20	$53.80	$508.00
___**5**	$193,001 to $499,999k	$386,001 to $749,999k	$559.00	$74.20	$633.20
___**6**	Greater than $500k	Greater than $750k	$594.00	$81.00	$675.00

2024 RATES DISPLAYED – MED SUP PLAN G IS NOW $240 DEDUCTIBLE FOR PART B EXPENSES

OTHER NOTES

_____

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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)*

Scope of Sales Appointment Confirmation Form

The Centers for Medicare and Medicaid Services (CMS) requires agents to document the scope of a marketing appointment prior to any face-to-face sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative.

Please mark beside the type of product(s) you want the agent to discuss.

Medicare Advantage Prescription Drug Plans (Part C) and Cost Plans

☐ **Medicare Preferred Provider Organization (PPO) Plan** — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and includes Part D prescription drug coverage. PPOs have network doctors and hospitals but you can also use out-of-network providers, usually at a higher cost.

☐ **Medicare Health Maintenance Organization (HMO) Plan** — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and includes Part D prescription drug coverage. With most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).

Stand-alone Medicare Prescription Drug Plans (Part D)

☐ **Medicare Prescription Drug Plan (PDP)** — A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans.

Additional Products

☐ **Dental/Vision**

☐ **Medicare Supplement (Medigap) Products**

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the Federal government. This individual may also be paid based on your enrollment in a plan.

Signing this form does NOT obligate you to enroll in a plan, affect your current enrollment, or enroll you in a Medicare plan.

Beneficiary or Authorized Representative Signature and Signature Date:	
Please Print:	
Name:	Phone:
Address:	
Signature: _____ **Signature Date:** _____	
If you are the authorized representative, please sign above and print below:	
Representative's Name: _____	
Your Relationship to the Beneficiary: _____	

To Be Completed By Agent:

Agent Name:	Agent Phone:
Initial Method of Contact: (Indicate here if beneficiary was a walk-in.)	
Agent's Signature:	
Plan(s) the agent represented during this meeting:	
Date Appointment Completed:	
[Plan Use Only:]	

Scope of Appointment (SOA) documentation is subject to CMS record retention requirements

Agent, if the form was signed by the beneficiary at time of appointment, provide explanation why SOA was not documented prior to meeting:

_____

_____