PROVIDER AND MEDICATION WORKSHEET

Name: _____ Phone: _____

Address: _____ Date of Birth:_____

City _____ State _____ Zip _____ Email: _____

County: _____ Seasonal Home Zip / County: _____

PART D MEDICATIONS FULFILLED AT PHARMACY

You may choose from one of the following options:

__ Stay with Original Medicare and add a separate Part D drug plan - complete page 1 only, or

__ Enroll in a Medicare Advantage plan including Part D coverage (MAPD) complete both pages, or

__ Enroll in a Medicare Advantage plan *without* Part D coverage (skip to page 2)

MY PREFERRED LOCAL RETAIL PHARMACY: _____

Check if applicable: [ ] I receive Social Security ***Extra Help*** for Part D premium, deductible and copays

[ ] My ***NY State EPIC*** ID is: _____

[ ] My ***State MEDICAID*** ID is: _____

Please list your current pharmacy filled (exclude over the counter) medications.

Please provide the exact spelling and complete information from the prescription label.

	Format	Dosage	Quantity
Ex: Atorvastatin	*tablet*	*125mg*	*2x daily*
1_____	_____	_____	_____
2_____	_____	_____	_____
3_____	_____	_____	_____
4_____	_____	_____	_____
5_____	_____	_____	_____
6_____	_____	_____	_____
7_____	_____	_____	_____
8_____	_____	_____	_____
9_____	_____	_____	_____

ONGOING PART B MEDICATION REC'D AT DR. OFFICE ? ___ NO ___ YES

Use additional pages if necessary

PROVIDER AND MEDICATION WORKSHEET

Name: _____

FOR MEDICARE ADVANTAGE PLANS

My Primary Care Provider Name: _____ Tel_____

Address _____ Medical Group _____

My preferred area hospital for elective / non-emergency care: _____

Any comprehensive dental care (excl cleanings) planned? ____ Yes ____No

SPECIALISTS I SEE (no matter how often)

1) Name _____ Group _____

Address _____

2) Name _____ Group _____

Address _____

3) Name _____ Group _____

Address _____

4) Name _____ Group _____

Address _____

5) Name _____ Group _____

Address _____

PRIORITIES – please note 3 (#1, 2 and 3) most important and (#10) least important to you

_____ Dental Coverage beyond routine cleaning

_____ Eyewear Allowance

_____ Over-the-Counter Allowance

_____ Lower Monthly Premium

_____ Nationwide Network of Doctors and Hospitals

_____ Medicare Part B Rebate (if applicable)

_____ Lower or $0 Drug Deductible

_____ Lower Doctor, Hospital, Outpatient and Lab Copays

_____ Hearing Aid Benefit

_____ Transportation for Medical Appointments

_____ Lowest Maximum Medical Annual Out of Pocket Costs

_____ Points or cash rewards for healthy habits

Use additional pages if necessary