Medicare Made Easy for Medicare Recipients

Living on the North Shore of Massachusetts

Name____Date of Birth ____/____/________

Address____

Phone number________________________Email ______________________________________

Are you currently covered by an employer healthcare plan? Yes____No____ If yes, are there more than 20 employees covered by the employer healthcare? Yes____No____

Enrolled in Medicare Part A? Yes____No____ If so, the Part A effective Date is :__________________

Medicare ID: _______________________Part B desired or actual effective date:________________

Current medical healthcare plan name: _______________healthcare plan ID:___________________

Healthcare premium cost per month: _______________Prescription drug cost/month:___________

How would you best describe your health condition?

___ Good – Visit doctors six or fewer times per year

___ Fair – Visit doctors every month or 12 times/ year; may require short hospital stay

___ Poor – Visit Doctor two times per month; may require multiple hospital stays

Do you have end-stage renal failure? Yes____No____

Would you require routine medical care if you were traveling out of your home area? Yes____No____

Do you travel internationally? Yes ____No_____

What type of premiums and co-pays would you rather pay for?

____Lower monthly premiums & pay higher co-pays when you go to the doctor or hospital?

____Higher monthly premiums and pay minimal co-pays when you go to the doctors or hospital?

Who is your primary care physician (PCP)?

Name **Address** **Phone**

____

If the lowest cost and highest rated Medicare plans are not accepted by your PCP, would you rather:

_______ Explore only plans my PCP accepts? _______ Or explore other highly rated PCPs near me that do accept the lowest cost/highest rated plans?

Who are your medical specialists?

Name	Address	Phone

Do you take prescription medications? Yes ____No_____Preferred Pharmacy?:___________________

Prescription Drugs

Name	**Dosage**	**Frequency**

Do you wear glasses or contacts? ______Prefer gym membership? ______ Prefer a Dental plan?_____

Qualify for Masshealth Standard (< $1,005/month)? ____Medicaid Number: _____________________

Do you qualify for frail senior Medicare Advantage? (Two ADLs + income < $2,000/mo.)?___________

Do you get other financial help? ____

Do you have an authorized representative? (I.e. POA) Name___________________________________

Authorized Representative's contact phone: ____

Was your modified adjusted gross income as reported on your IRS tax return from two years ago greater than $87,000 filing as an individual or $174,000 filing joint?Yes_____No_____

Any other information you wish to share: ____

Please return this worksheet to: bbullen@nsshealth.com or North Shore Senior Healthcare, 8 Hardy Road, Swampscott MA 01907.