North Shore Senior Healthcare

Medicare Made Easy for Medicare Recipients

Living in CNY and 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?_____

Are you collecting SSA income? ___

Do you qualify for State Medicaid? ____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 2021 greater than $97,000 filing as an individual or $194,000 filing joint? Yes_____No_____

Please return this worksheet to: bbullen@nsshealth.com or North Shore Senior Healthcare, 4477 Ridge Road, Cazenovia, NY 13035.