| Medicare Profile | |
|---|---|
| Address: | |
| Name: _____ POA: Y / N<br>DOB: _____ Current Plan: _____<br>Medicare#: _____ A/B: _____<br>Medicaid/level/LIS: _____<br>Email: _____<br>Phone #: _____ | Name: _____ POA: Y / N<br>DOB: _____ Current Plan: _____<br>Medicare/MBI:_____ A/B: _____<br>Medicaid/level/LIS: _____<br>Email: _____<br>Phone #: _____ |
| What do you like about your plan now?<br>What do you not like about your plan now? | |
| Medications/Inhalers:<br>Pharmacy: _____<br>Name, dosage/day, fill every 30/90:<br>_____<br>_____<br>_____<br>_____<br>Do you use: c-pap wheelchair oxygen | Medications/Inhalers:<br>Pharmacy: _____<br>Name, dosage/day, fill every 30/90:<br>_____<br>_____<br>_____<br>_____<br>Do you use: c-pap wheelchair oxygen |
| Doctors<br>Primary:<br>Specialists:<br><br><br>Dentist:<br>Eye Doctor: | Doctors<br>Primary:<br>Specialists:<br><br><br>Dentist:<br>Eye Doctor: |

Do you have Dental work coming up?

Do you wear glasses?

Do you need hearing aids?

Would it be helpful if you had OTC benefits?

Do you have anyone in your family who had cancer or heart attack or Stroke?

Do you know anyone who has been hospitalized in the past 5 years?

Notes/Other concerns?_____

_____

_____