JB Gross Insurance Agency LLC

817-613-1098 www.jbgross.com Fax 817-613-1360

Medicare Information Sheet

Full Name:____Referred By:________________________________

Gender: ☐ Male / ☐ Female DOB:_____________ Tobacco Use: ☐ Yes / ☐ No Height:____/____ Weight:_____lbs

Ùd^^cÁŒåå¦^••: _______________________________City:_______________Zip:_________County:__________

E-mail Address:______________________________ ☐ Single / ☐ Married ☐ Other:_____________

Home Phone: (____)______-______ Cell Phone: : (____)______-______ Work Phone: (____)______-______

Preferred Phone:____________________________________

Requested Effective Date:___________Primary Contact Person for Additional Informaton:_____________________

Medicare ID #:________________ Part A Effective Date:____/____/____ Part B Effective Date:____/____/____

Types of Coverage to be Quoted

☐ Medicare Supplement ☐ Prescription Drug Plan (PDP/RX)

☐ PPO Medicare Advantage ☐ HMO Medicare Advantage

Reason for Enrolling:

☐ Initial Enrollment Period (IEP) ☐ Annual Enrollment Period (AEP) ☐ Special Enrollment Period (SEP)

Needs Assessment: Is there a family member, friend, or Power of Attorney that helps you make decisions on your medical care?

☐ Yes / ☐ NO If yes, who? ____

Contact information:____

Current Coverage: Carrier's Name:____________________________________Date Coverage Ends:________________

Are you an AARP Member? ☐ YES / ☐ NO Do you have End Stage Renal Disease (ESRD)? ☐ YES / ☐ NO

Are you on Medicaid? ☐ YES / ☐ NO Do you get extra help through Social Security? ☐ YES / ☐ NO If yes, what kind?____

Provider Check: List your *PHYSICIANS, LABORATORY* and *HOSPITALS* ***(Current and any you plan to see in the next 24 months)***

PHYSICIAN or FACILITY NAME	PROVIDER TYPE	PHONE NUMBER	CITY & ZIP CODE

Pharmacy Check: List your preferred *PHARMACY information (mail order pharmacies can be listed)*

PHARMACY NAME	PHONE NUMBER	CITY & ZIP CODE

Prescription Check: List *ALL PRESCRIPTIONS,* including *TYPE* (Capsue/Tablet/Liquid, Etc.) *DOSE & TIMES TAKEN PER DAY*

Exact spelling of RX as written, including acronyms	Prescribed Frequency	Specific Dosage	Retail or Mail Order	Notes
Example: Losartan Potassium/HCTZ	**Example:** 1 x day	**Example:** 100 mg	**Example:** Mail Order	**Example:** I take this drug daily in the morning

**Print additional sheets if needed for provider or prescription information*

Signature____ Date_______________

Agent Office Use Only

Date Submitted:_______________ Submitted Via: ☐ Email ☐ Fax ☐ In Person ☐ Mail Information taken by:_______________

Notes: ____

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