Medicare Preparation Worksheet

Name: _____ **Birthday:** _____ **Phone:** _____ **Email:** _____

City: _____ **County:** _____ **Zip:** _____ **Today's Date :** _____

Current or Proposed Medicare Effective Date: _____ **Part A Effective Date:** _____ **Part B Effective Date:** _____

Your Current Insurance: _____ **Medicare Enrollment Code: AEP**_____**IEP**_____**SEP**_____

List your doctors below & call your doctors and ask if they accept…	Medicare Supplement Plans (which companies)	Medicare Advantage Plans (which companies)

Your Prescriptions for Medicare Part D **Medicare.gov U/N:** _____ **Date:** _____

Your 2 preferences for drug stores: 1)_____ **2)**_____

Name of Medication	Dosage of Medication	Frequency of Use of Rx
		1x/day

Fax to 1-866-480-7462 or email to info@healthlifegroup.com

SUBMIT