TODAY'S DATE: _______________

MEDICARE CALL SHEET

CLIENT EMAIL: ____

SOURCE: ____________________________

CLIENT PHONE NUMBER: _______________________________

AGENT:____________________________Appointment Date & Time:_________________________________

NAME:____GENDER:__________ D.O.B.__________________

ADDRESS:____COUNTY:_____________________

CITY: _________________________ STATE: ___________________ ZIP CODE: ____________________

CURRENTPLAN: _______________________________________ Effective Date: ___________________

MEDICARE #: __________________ Part **A** effective date: __________Part **B** effective date: ________

MEDICATIONS DOSAGE FREQUENCY

1)____

2)____

3)____

4)____

CURRENT RX PLAN: _____________________________________ Effective Date: _________________________

PHARMACY: ___________________________ ADDRESS: ____

TOBACCO USE: YES____NO_____ MEDICAID: YES___NO _____

If yes, go to www.YourTexasBenefits.com. If no, check LIS chart.

END STAGE RENAL DISEASE: YES_______NO _____ **DIALYSIS**: YES______NO _____

ALS (Amyotrophic lateral sclerosis): YES___NO _____ **CHRONIC ILLNESS**: YES___NO _____

LIVE IN LTC Facility: YES ____ NO ______ (may qualify for **CIP** or **SNP** (such as diabetes)

DOCTORS NAME ADDRESS PHONE NUMBER SPECIALTY

1)____

2)____

3)____

DENTAL: YES___NO _____ VISION: YES_____NO _____

INDEMINITY PLAN: YES__NO _____

ENROLLMENT PERIOD?
AEP? IEP? ICEP? SEP?

References: 1) www.Medicare.gov
2) www.SSA.gov (Medicare card or replacement card)
4) www.BenefitsCheckUp.org
5) www.YourTexasBenefits.com

Future Appointment Time & Date: ________________ Final Expense? Life? LTC?