Medicare Needs Assessment
Pre-Meeting Profile

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My information

First name | Last name

Permanent address *(please include city, state and ZIP)*

County | Phone | Email

1. Are you a current Medicare beneficiary or are you getting ready to transition into Medicare?

☐ Current ☐ Transitioning Date of birth: ____/____/____

Part A effective date: _____ Part B effective date: _____

2. What kind of health plan are you currently covered by?

Employer-Provided Group Plan
- ☐ fewer than 20 employees
- ☐ more than 20 employees

☐ Individual
☐ COBRA
☐ ACA
☐ VA

☐ Original Medicare only
☐ Medicare Supplement
☐ Part D Rx Plan
☐ Medicare Advantage Plan

☐ Dental
☐ Vision
☐ Hearing

3. What do you consider to be the most important aspects of a health plan? (Select all that apply)

☐ Providers
☐ Network flexibility
☐ Prescription inclusion and cost
☐ Premium and copay/ coinsurance cost
☐ Being approved without underwriting
☐ Additional benefits, such as gym membership, transportation, dental/vision/hearing

Other: _____

4. A. Do you have a primary care physician? ☐ No ☐ Yes
   If yes, name of physician: _____
   Number of visits in the last 12 months: _____
   B. Do you currently see a specialist? ☐ No ☐ Yes
   If yes, name of specialist: _____
   Number of visits in the last 12 months: _____
   C. Do you have a preferred hospital? ☐ No ☐ Yes
   If yes, name of hospital: _____
   Number of visits in the last 12 months: _____
   D. Do you have a preferred pharmacy? ☐ No ☐ Yes
   If yes, name of pharmacy: _____

5. Do you live part-time in another state? ☐ No ☐ Yes
   If yes, how many months of the year? ☐ 0-3 ☐ 3-6 ☐ 6-9+

(Continued on page 2)

Prescribed Medication List

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Optional: I am submitting my list of medications (excluding any over-the-counter or herbal medications) because I am requesting your assistance in helping me to identify appropriate Medicare Part D prescription drug plan options.

Name: _____

Medications I am currently taking					
Drug name	Dosage	Form (e.g. aerosol, cream, tablet, capsule)	Frequency of dosage (e.g. 1/day)	Frequency of refills (e.g. 30 or 90 days, 2x/yr, 1x/yr)	Quantity of refill

Please return this form to MDA Insurance by email to steve@mdaifg.com or FAX to 517-484-5460 at least 72 hours prior to your Medicare appointment.

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