Medicare Plan Comparison Patient Intake Form

NAME: ____ DOB: ________________________

ADDRESS: ____

PHONE#: ____________________________ EMAIL: _________________________________

PREFERRED CONTACT METHOD (circle one): CALL TEXT EMAIL

MEDICARE A/B ID#: ________________________

CURRENT PLAN INFORMATION

PLAN NAME: ______________________ PLAN CODE: _________________________

RX BIN: ______________ RX PCN: _________________ RX GROUP: ______________

IS THIS A MEDICARE ADVANTAGE PLAN: Y N

DO RECEIVE SUBSIDIES FROM THE GOVERNMENT, AND/OR ARE YOU ENROLLED WITH MEDICAID? Y N

MEDICATION LIST

MEDICATION NAME	STRENGTH	DOSE	TAKEN DAILY?

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Are you a current patient at Family Pharmacy Cumberland, Farmville, or Amelia? (If YES please circle which pharmacy) **Y** **N**
2. When choosing a plan, how important is it for you to be able to receive services from this pharmacy?
   Very Important **Somewhat Important** **Not Important**
3. Are you happy with your current plan? **Y** **N**
4. If no, why? ____
5. Do you prefer a traditional Medicare Part D Plan or a Medicare Advantage plan? (Circle One)
6. What medications are you most concerned about having coverage and are you open to finding alternatives if needed?
   ____

7. When considering a plan, are you more concerned about the amount you would spend monthly on the premium or the amount you would spend over the entire year? ________________________________
(For example, a plan with no deductible may be lower per month but may not be the least amount spent over the course of the year)

8. Do you need help from someone to manage your medications?

9. Do you rely on someone else for transportation?

10. Would you like your plan review results emailed to you or would you like to pick them up at the pharmacy? ____

11. Yes! Please keep me up to date with what's going on at Family Pharmacy including specials and promotions via email! **Y** **N**