IYC65
IN YOUR CORNER

Medicare Advantage Consultation Form

Full Name: _____ **Zip Code:** _____

Date of Birth: _____ **Age:** _____ **Medicare #:** _____

Address: _____ **City:** _____

E-mail: _____ **Phone:** _____

Do you have Medicaid? ☐ Yes ☐ No **Are you a Veteran?** ☐ Yes ☐ No

Please check any of the following pre-existing conditions that apply:

☐ Diabetes mellitus ☐ Chronic heart failure

☐ Cardiovascular disorders

Current Medications	Dose	Quantity

Doctors - Include first, last name & specialty: _____

_____

_____

Current Plan: _____ **Recommended Plan:** _____

Desired coverage start date: _____

Additional Medications	Dose	Quantity

Additional Doctors : _____

_____

_____

_____

_____

_____