Medicare Supplement Client Intake Sheet

DATE:_____

Name:_____ Birthdate:_____

Current Plan:_____Current Price:_____ Pays Monthly?_____
Current Drug Plan:_____ Price:_____ Any problems?_____

Address:_____

Health Concerns:_____
Ht_____ Wt_____ Smoker_____ On Medicare Disablity? On MEDICAID?_____

Medications
_____
_____
_____
_____
Primary Care Dr_____ Hospital_____
Specialists need in network_____

Does S/he live in state year round or spend a lot of time out of state?_____

Medicare #_____Part A_____ Part B_____

Plan(s) Recommended_____
Follow Up_____
_____
_____

Mailed Kit date_____ Set face to face_____
Received application / submitted to carrier_____
Called Back _____