



Medicare - New Client Intake Form

Name on Card Preferred Name

Physical Address City Zip County

Mailing Address, if applies City Zip

Employer

Cell Text? YES NO Home Phone

Personal Email Work Email

Social Security Medicare Number

Date of Birth Part A Effective Date Part B Effective Date

Male Female Single Married Mother's Maiden Name

Spouse's Name Spouse's Date of Birth

Current Pharmacy Mail-order? YES NO

Nicotine use? YES NO If yes, type Height Weight

Possible Federal Programs Due to Income, if qualify: Over \$91,000/year? YES NO Under \$1,529/month YES NO

Do you currently receive any of the following benefits?

Veteran? YES NO **TriCare?** YES NO **Receive medication from VA?** YES NO **Extra Help/LIS?** YES NO

SSDI YES NO **SSI** YES NO **Medicaid?** YES NO **Medicaid Number**

Current Health Coverage (Group, Individual, MAPD, Med Sup, HMO, PPO, Dual Special Needs, Chronic Special Needs, Disability)?
 Expiration Date

Referral Source: **Who can we thank?** (Name, Facebook, Phonebook, Website, Postcard, Other)

Access to your Medicare.gov account allows us to save medication lists and compare your options.
(This is NOT the same as your Social Security Account.)

Do you have a Medicare.gov Account to which we can have access? YES NO

Username Password

If none, do we have permission to create an account for you? YES NO

Security Question for Future Password Reset Purposes (answer only one):

What city did you meet your spouse?

What was the name of your first pet?

What is the name of the first street you lived on?

You will receive a one-page letter from Centers for Medicare and Medicaid regarding account access if we set up your account.

Please list all of your current prescription medications as they are written on your medication bottles (list generic name if used).
 List only medications prescribed by your doctor and do not include over-the-counter items.

Example: Rx Name – Lisinopril Dosage - 20 mg How often – 2 x day Type - Tablet

| Name of Prescriptions expected in the next 12 months | Strength | Frequency | Tablet, Capsule, Gel, Cream, Spray | Condition/Diagnosis |
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Medicare Advantage plans have HMO or PPO networks that you must use.
 If you are interested in Medicare Advantage Plans, please list all providers you currently use.
 If more space is needed for medications or providers, please attach on a separate sheet.

Primary Care Physician

Name (First & Last)

Office Address Phone

Preferred Hospital

Facility Name City

Specialists (Doctors, Dentists, Durable Medical Equipment providers, etc.)

Name (First & Last) Specialty

Office Address Phone

Name (First & Last) Specialty

Office Address Phone

Name (First & Last) Specialty

Office Address Phone

AUTHORIZATION

I have voluntarily provided the information on this sheet to CHAMP, dba Customized Health And Medicare Plans to aid in the choice of individual health plan(s). I am pursuing their advice for health plan(s) that will best service my needs. I agree to receive my personal, no cost, no obligation recommendation, and I further authorize a licensed sales agent to contact me by phone, text, email, or mail, if needed. This information, provided to Customized Health And Medicare Plans, is not to be used for any purpose other than for my health plan(s) selection. I understand I am not bound to accept their recommendation. By returning this form, I am authorizing a licensed agent from Customized Health And Medicare Plans to contact me regarding my healthcare needs.

Signature Date

Scope of Appointment Confirmation Form

Before meeting with a Medicare beneficiary (or their authorized representative), Medicare requires that Licensed Sales Representatives use this form to ensure your appointment focuses only on the type of plan and products you are interested in. A separate form should be used for each Medicare beneficiary. **Please check what you want to discuss with the Licensed Sales Representative.**

- | | |
|---|---|
| <input type="checkbox"/> Medicare Advantage Plans (Part C) and Cost Plans | <input type="checkbox"/> Dental-Vision-Hearing Products |
| <input type="checkbox"/> Stand-alone Medicare Prescription Drug Plan (Part D) | <input type="checkbox"/> Hospital Indemnity Products |
| <input type="checkbox"/> Medicare Supplement (Medigap) Plan | |

By signing this form, you agree to meet with a Licensed Sales Representative to discuss the products checked above. The Licensed Sales Representative is either employed or contracted by a Medicare plan and may be paid based on your enrollment in a plan. They **do not** work directly for the federal government.

Signing this form **does not** affect your current or future enrollment in a Medicare plan, enroll you in a Medicare plan or obligate you to enroll in a Medicare plan. All information provided on this form is confidential.

| |
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| Beneficiary or Authorized Representative Signature and Signature Date: |
|---|

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|---|--------------|
| Signature of applicant/member/authorized representative | Today's Date |
|---|--------------|

If you are the authorized representative, please sign above and print clearly and legibly below:

| | |
|-------------------|-----------------------------|
| Name (First_Last) | Relationship to Beneficiary |
|-------------------|-----------------------------|

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|--|
| To be completed by Licensed Sales Representative (please print clearly and legibly) |
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| | | |
|---|-------------------------------------|------------------------------------|
| Licensed Sales Representative Name (First_Last) | Licensed Sales Representative Phone | Licensed Sales Representative ID |
| Beneficiary Name (First_Last) | Beneficiary Phone | Date Appointment will be Completed |

Beneficiary Address

| | |
|---------------------------|---|
| Initial Method of Contact | Plan(s) the Licensed Sales Representative will Represent During the Meeting |
|---------------------------|---|

Licensed Sales Representative Signature

| Medicare Advantage Plans (Part C) and Cost Plans |
|---|
| <p>Medicare Health Maintenance Organization (HMO) – A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan’s network (except in emergencies).</p> |
| <p>Medicare HMO Point-of-Service (HMO-POS) – A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. HMO-POS plans may allow you to get some services out of network for a higher copayment or coinsurance.</p> |
| <p>Medicare Preferred Provider Organization (PPO) Plan – A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors, providers and hospitals but you can also use out-of-network providers, usually at a higher cost.</p> |
| <p>Medicare Private Fee-For-Service (PFFS) Plan – A Medicare Advantage Plan in which you may go to any Medicare-approved doctor, hospital and provider that accepts the plan’s payment, terms and conditions and agrees to treat you – not all providers will. If you join a PFFS Plan that has a network, you can see any of the network providers who have agreed to always treat plan members. You will usually pay more to see out-of-network providers.</p> |
| <p>Medicare Special Needs Plan (SNP) – A Medicare Advantage Plan that has a benefit package designed for people with special health care needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in nursing homes, and people who have certain chronic medical conditions.</p> |
| <p>Medicare Medical Savings Account (MSA) Plan – MSA Plans combine a high deductible health plan with a bank account. The plan deposits money from Medicare into the account. You can use it to pay your medical expenses until your deductible is met.</p> |
| <p>Medicare Cost Plan – In a Medicare Cost Plan, you can go to providers both in and out of network. If you get services outside of the plan’s network, your Medicare-covered services will be paid for under Original Medicare but you will be responsible for Medicare coinsurance and deductibles.</p> |
| Stand-alone Medicare Prescription Drug Plans (Part D) |
| <p>Medicare Prescription Drug Plan (PDP) – A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-For-Service Plans, and Medicare Medical Savings Account Plans.</p> |
| Other Related Products |
| <p>Medicare Supplement (Medigap) Products– Insurance plans that help pay some of the out-of-pocket costs not paid by Original Medicare (Parts A and B) such as deductibles and co-insurance amounts for Medicare approved services.</p> |
| <p>Dental/Vision/Hearing Products – Plans offering additional benefits for consumers who are looking to cover needs for dental, vision, or hearing. These plans are not affiliated or connected to Medicare.</p> |
| <p>Hospital Indemnity Products– Plans offering additional benefits; payable to consumers based upon their medical utilization; sometimes used to defray copays/coinsurance. These plans are not affiliated or connected to Medicare.</p> |