PA MEDI Beneficiary Intake Form

Beneficiary Information

First Name: ___________________________ Last Name: ____________________________

Phone Number: _______________________ Address: ______________________________

Email: ____________________________ ______________________________

Do you have a Medicare Account? ☐ Yes ☐ No ☐ I don't know

If yes:
Username: ___________________________ Password: ___________________________

Health Insurance Information

Current Coverage: ☐ Medicare Advantage ☐ Prescription Drug Plan ☐ New to Medicare

Current Plan Name/Company: ____

Current Monthly Premium: $ ____________________

Financial Assistance Information

Do you have PACE or PACENET? ☐ Yes ☐ No ☐ I don't know

Do you have Extra Help? ☐ Yes ☐ No ☐ I don't know

Do you have Medicaid? ☐ Yes ☐ No ☐ I don't know

Current Medical Providers

Primary Care Provider	Practice Name & Location
Specialist	**Practice Name & Location**
Hospital	**Location**

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List of Current Medications

Medication Name	Dosage	Frequency

Pharmacy Information

Current Pharmacy: ____

Address: ____

Is this your preferred pharmacy? ☐ Yes ☐ No ☐ I don't know

Are you open to using other pharmacies if your prescription costs are lower? ☐ Yes ☐ No

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