

Beneficiary Intake Form

This worksheet provides the necessary information that PA MEDI volunteers and staff need to prepare a personalized comparison report for you. PA MEDI does not endorse any Medicare Advantage or Part D Prescription Drug Plan. Any information provided on this form will not be sold, shared, or used for any other purpose besides providing you with a plan comparison.

Name:	Date of Birth:
Address:	
City:	State: Zip:
County:	Phone:
Email Address:	
Appointment Preference: In-Person Appointmen	nt Phone Appointment
Medicare Login I have a Medicare Account A Medicare account login is needed for your appointment have a Medicare.gov account login, please provide your	nt. If you would like a personalized search and already
Username:	Password:
If you do not have a Medicare.gov account, or are not su create an account for you. You will need to have your M	<u> </u>
Health Insurance Information: Do you have a	any of the following coverages?
☐ Medicaid ☐ Tricare ☐ VA	☐ Federal Employee Benefits
☐ PA State Retiree Benefits ☐ HOP	☐ Other:
Do you currently have a stand-alone Part D D	Drug Plan or a Medicare Advantage Plan?
☐ Yes ☐ No ☐ I don't know	
Current Plan Name/Company:	
Current Monthly Premium: \$	
Do any of the following apply to you?	
□ PACE □ PACENET □ Extra Help	☐ The state pays my Part B Premium
FOR OFFICE USE ONLY	

Current Medical Providers

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

List of Current Medications

Medication Name	Generic ok? Y/N	Strength/Dosage	Frequency	How often do you refill this Rx?
Example: Lipitor	Y	Example: 20 mg	Example: 1 per day	Example: 90 day supply

Pharmacy Information

Preferred Pharmacy and Location:	
Are you open to using other pharmacies or mail order if your prescription costs are lower?	
☐ Yes ☐ No	
NOTES:	