Client Needs Assessment

Name

Phone

Text? Y or N

Email

Contact preferred

Address

Are you a current Medicare beneficiary or new to Medicare? ◯ Current ◯ New

Effective Date Part A

Effective Date Part B

Medicare #

Medicaid # (if applicable)

Are you a veteran? ◯ Yes ◯ No

If yes, which branch?

Spouse

Are you married? ◯ Yes ◯ No

If yes, name

Spouse DOB

Veteran? ◯ Yes ◯ No

On Medicare? ◯ Yes ◯ No

Plan name

Premium

POA

Do you have a Healthcare POA or someone who helps with medical decisions? ◯ Yes ◯ No ◯ Spouse

Name

Relationship

Email

Phone

Current Coverage

☐ ACA ☐ Cobra ☐ VA ☐ Tricare ☐ Medicaid ☐ Med-Supp ☐ Original Medicare

☐ Company Provided Plan (currently working) ☐ Company Provided Retirement Plan

☐ Medicare Advantage Plan ☐ Medicare Advantage Special Needs Plan

◯ Dental ◯ Vision ◯ Hearing ◯ Indemnity ◯ Other

Carrier: Plan: Premium:

Carrier: Plan: Premium:

Carrier: Plan: Premium:

If you could change anything about your healthcare coverage, what would it be?

☐ Premium Cost ☐ Copay/Coinsurance Cost ☐ Providers ☐ Plan Structure ☐ Benefits

☐ Other

What parts of your current coverage do you like?

Why are you wanting to make changes now?

☐ Aging in ☐ Annual renewal ☐ Other: (Please describe)

☐ Moving ☐ New diagnosis

☐ Change in finances ☐ Exploring my options

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Belle Vida INSURANCE

What do you consider to be the most important aspects of medical coverage? (Select any that apply)

☐ Providers ☐ Prescription Cost ☐ Premium Cost ☐ Copay Cost

☐ Anything else? ______

______

PCP/ Hospital/ Dentist

Do you currently have a Primary Care Physician (PCP)? ☐ Yes ☐ No

If so, who? Name ______ Location ______

Would you consider changing PCP if it meant getting into a plan that better suits your needs? ☐ Yes ☐ No

What hospital networks do you use? ______

Do you have/need dentures, crowns, bridges or implants? ☐ Yes ☐ No

If so, please describe: ______

Dentist name: ______ Location: ______

Prescriptions

Are there any prescriptions that need to be included in a plan, that you'd like to preview the cost? ☐ Yes ☐ No

Prescription(s): see example below

Name:		Dosage			Times Per	
Name:	Lisinopril	Dosage	10 mg	2 x	Times Per	day
Name:		Dosage			Times Per	
Name:		Dosage			Times Per	
Name:		Dosage			Times Per	
Name:		Dosage			Times Per	
Name:		Dosage			Times Per	
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Name:		Dosage			Times Per	
Name:		Dosage			Times Per	
Name:		Dosage			Times Per	

What pharmacy do you use? ______ Location ______

Specialty/ Part B drugs? ______

Would you like information about any plans in the area that may offer special coverage for beneficiaries with certain medical conditions, including diabetes, heart conditions, or Chronic Obstructive Pulmonary Disease (COPD) (depending upon local availability)? ☐ Yes ☐ No

Are you concerned about paying for things like copays, deductibles, and coinsurance? ☐ Yes ☐ No

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