

**Medicare and Prescription Drug Check Up Form**

*Allow Schneider Senior Solutions to compare all your plan options for you!*

Step 1: Please fill out this entire form, sign and date, and mail to:

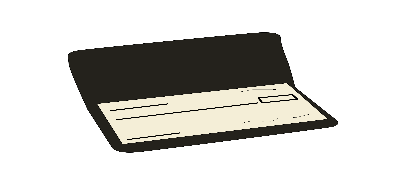
***Mail – Schneider Insurance, 120 Mill St, Gahanna, OH 43230***

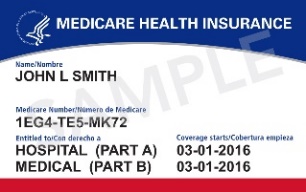
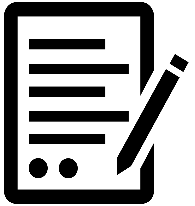
***Email –*** [***amanda.schneider@schneiderins.com***](mailto:amanda.schneider@schneiderins.com)

***Text – (614)571-6922***

Once received, we will contact you for your free personalized plan review.

Or: Call Amanda Schneider at 614-571-6922 to schedule your free personalized review.

 Step 2: What do I need to have ready for my appointment? The four important items below:



**Your Medicare Card**

**Your Current Insurance Card (s)**

**This Completed Form**

**Your Checking/Savings Info**

**( In Case It Is Needed)**

Your Name Date of Birth

Mailing Address Gender

City State Zip Code County

Home Phone Cell Phone

What current medical plan do you have (as listed on your insurance ID card or bring it with you)

Do you travel? YES or NO If yes, for how long?

Please list your preferred physicians, including full name, specialty, and office address. (Please do not include dentists)

**Primary Care/Family Doctor**

Name (First & Last)

Office Address

Your Preferred Hospital Hospital City

Please list any health conditions you may have ­

**Specialists**

Name (First & Last) Specialty

Office Address

Name (First & Last) Specialty

Office Address

Name (First & Last) Specialty

Office Address

**Prescriptions**

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. If you need additional space, attach a separate sheet of paper. Have this form available at   
your appointment along with the four pictured items listed above. Please fill out completely to assist us in helping you.

Example: **Rx Name** – Lisinopril **Dosage**- 20 mg **How Often**- 2 X a day

Rx Name Dosage How Often

Rx Name Dosage How Often

Rx Name Dosage How Often

Rx Name Dosage How Often

Rx Name Dosage How Often

Rx Name Dosage How Often

Top 2 Pharmacies Used (1): (2):

Do you use Mail Order Pharmacy: Yes \_\_\_\_Or No\_\_\_\_?

**Authorization**

I have voluntarily provided the health information on this sheet to <Insert Name> to aid in the choice of an individual/group health plan. I am pursuing their advice for a Medicare plan that will best serve my needs. I agree to receive my personal no cost, no obligation recommendation and I further authorize <Insert Name> to contact me by phone or mail, if needed. This information, provided to <Insert Name> on this form, is not to be used for any purpose other than for my Medicare health plan selection. I understand I am not bound to accept their recommendation. By signing below, I am authorizing a licensed agent from <Insert Name> to contact me regarding my healthcare needs.

Signature Date

POA Signature (Only if applicable) Date