

Medicare Annual Review

Client Questionnaire

Please complete this form and bring it to your upcoming review appointment, along with your current Medicare card and prescription drug list.

Section 1: Beneficiary Information

Full Name: _____ Date of Birth: ____ / ____ / ____

Phone: (____) ____ - ____ Email: _____

County of Residence (Michigan): _____

Medicare Number (MBI): _____

Part A Effective Date: ____ / ____ / ____

Part B Effective Date: ____ / ____ / ____

Section 2: Current Coverage Overview

Which type of Medicare coverage do you currently have? (Check one)

☐ Original Medicare + Medigap (Supplement) + Stand-Alone Part D Drug Plan

Medigap Carrier & Plan Type (e.g., Plan G, Plan N): _____

Part D Plan Carrier Name: _____

☐ Medicare Advantage Plan (Part C)

Current Carrier & Plan Name: _____

☐ Unsure / Need help identifying my plan

Section 3: Current Prescription Medications

Under 2026 federal guidelines, out-of-pocket costs for covered Part D prescription drugs are capped at \$2,100 per year. Listing all medications helps us optimize your drug plan costs.

Medication Name	Dosage	Frequency	How Do You Refill?
1. _____	_____	_____	☐ Retail ☐ Mail Order
2. _____	_____	_____	☐ Retail ☐ Mail Order
3. _____	_____	_____	☐ Retail ☐ Mail Order
4. _____	_____	_____	☐ Retail ☐ Mail Order
5. _____	_____	_____	☐ Retail ☐ Mail Order
6. _____	_____	_____	☐ Retail ☐ Mail Order

Preferred Local Pharmacy: _____

Preferred Online Pharmacy: _____

Section 4: Healthcare Providers & Health Systems

List your key doctors and hospitals so we can ensure they remain in-network for the upcoming year.

Primary Care Physician (PCP): _____

Clinic / Health System (e.g., Corewell, Trinity, Henry Ford, McLaren): _____

Specialist 1 (Name & Specialty): _____

Specialist 2 (Name & Specialty): _____

Preferred Hospital / Medical Center: _____

Section 5: Annual Preferences & Cost-Saving Screening

Healthcare Changes: Have you had any major health condition changes, upcoming surgeries, or new medical needs planned for the next 12 months?

☐ Yes ☐ No (If yes, brief detail: _____)

Monthly Expenses: Would you like to evaluate the Medicare Prescription Payment Plan (MPPP) to spread your prescription copays into predictable monthly payments rather than paying upfront at the pharmacy?

☐ Yes ☐ No ☐ Tell me more

Supplemental Benefits (Medicare Advantage Users): Which extra benefits are most important to you? (Check top 3)

☐ Dental Coverage

☐ Vision / Eyewear

☐ Hearing Aids

☐ Over-the-Counter (OTC) Allowance

☐ Fitness / Gym Membership

☐ Food / Utility Assistance

Financial Assistance Check: Do you receive Extra Help (Low Income Subsidy) or Michigan Medicaid assistance with your Medicare premiums/costs?

☐ Yes ☐ No ☐ Unsure (Please screen me for assistance programs)

Client Signature: _____ Date: ____ / ____ / ____