AZIRS Medicare Worksheet

Name: _____ DOB: _____

Address: _____

Phone: _____ Email: _____

Medicare #: _____ Part A: _____ Part B: _____

Current Plan: Medicare Advantage __ HMO __ PPO __ POS __ SNP __ PFFS __ AHCCCS __
Company: _____ Started: _____
Medicare Supplement Plan: _____Company: _____ Started: _____

Current Part DRX Plan: _____ Date Started: _____

Doctor(s)/ Specialists

Name: _____ Primary ___ Specialist ___
Address: _____ Phone: _____
_____

Name: _____ Primary ___ Specialist ___
Address: _____ Phone: _____
_____

Name: _____ Primary ___ Specialist ___
Address: _____ Phone: _____
_____

Name: _____ Primary ___ Specialist ___
Address: _____ Phone: _____
_____

Name: _____ Primary ___ Specialist ___
Address: _____ Phone: _____
_____

Hospital

Name of Hospital: _____
Address: _____

Phone: _____

Current Medications

Medication	Dosage	How Often	30,60 or 90 days
Example: Lisinopril	20 mg	1 x day	90 days

Pharmacy Name: _____

Address: _____

_____

Please Indicate Type of Research Needed:

Medicare Advantage Plans for 2024 _____

Medicare Part D Rx Plans 2024 _____

Medicare Supplement 2023/24 _____

Signature:_____ **Date:** _____

Please remember, we are always here for you! If you have questions or need help understanding your options, please feel free to give us a call!

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