INSURANCE MARKETING

Forward completed form to: chelsea@qaim.com or fax to: (800) 311-2100

Medicare Questionnaire - New or Current Client

First Name:_____ Last Name:_____

DOB:_____ Email: _____

Physical Address:_____

City: _____ State:_____ Zip:_____ County: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone: _____ Employer: _____

Medicaid / MediCal? _____ Prescription Assistance? _____ Dental Needs? ☐

Medicare ID #: _____ Part A Date: ___/___/____ Part B Date: ___/___/___

Current Coverage: _____ Cost: _____ Vision Needs? ☐

Any Special needs? _____

Helper Name: _____

Helper Address: _____

Helper Phone: _____ Email: _____

PCP: _____ Phone: _____

Specialist: _____ Phone: _____

Specialist: _____ Phone: _____

Drug Name	**Dosage**	**Frequency**

INSURANCE MARKETING

Comments / Extra Instructions