Medicare Advantage Evaluation Form

Oklahoma, Texas, Louisiana, and Mississippi

Date_____

Are you currently on MAPD? Please check your current plan or write it below _____ WellCare _____Humana _____ UHC Other Plan _____

Who is your Primary Physician? _____

Do you see any other Physicians?

_____

Have you been diagnosed with Diabetes, Cardiovascular, or Respiratory Conditions? __yes or no ___

If yes, what medications are you taking for that condition only?

_____

Notes:_____

Personal Information

First Name _____ Last Name _____ MI ___

Mailing Address _____

City _____ State _____ Zip Code _____

Phone Number (_____) - _____-_____

Social Security Number_____-_____-_____ (only if you do not have a Medicare card).

Date of Birth: _____/_____/_____

Medicaid Number _____

Medicare Number_____

Part A date_____ Part B date _____

LIS Level _____ Medicaid Level _____ Plan Selected _____

Enrollment Complete _____ HRA _____

Photo Consent _____ Cancer_____ Life_____

Thank You _____ File _____

Signature _____ **Date**_____