Date: _______________ **Personal Information Sheet (one per person)** Referred by: ____________________

Name____**DOB**________________**Phone**________________________

Address_____________________________________**City**_____________________ **State**_________**Zip**_______________

County___________________ , USA **Email**_________________________________ **Tobacco Use last 12 months?**_______

What health coverage do you currently have? (Mark box that applies):

Individual **Employer** **Retiree** **Plan Name**__________________________ **Drug Coverage Included**?______

Medicare Advantage Plan Name (HMO/ PPO) ____(on your Insurance Card)

Medicare Supplement Company Name__________________________ Plan(F, G, etc.) ________(on your Insurance Card)

AND Plan Name of Current Prescription Drug Coverage ______________________________(on your Insurance Card)

Do you have Medicare?: Part A Part B **Mark here if you have a MY MEDICARE.gov** account set up

Veteran? (yes/no) _______ **Interested in a Plan with Health Club Membership?** (yes/no) _________

Current Pharmacy Name/Mail Order (very important)____

MEDICATIONS - WE MUST KNOW EXACT INFORMATION TO GET AN ACCURATE DRUG ANALYSIS

Drug Name **Form** (Tab or Cap/ Inj/Vial/ Box/Patch/Inhaler/Lotion/Ointment/Drops)

______________________Mg/Mcg _____Form_____#/day_____How Often Refilled_____(see note BELOW) Generic OK?_____

______________________Mg/Mcg _____Form_____#/day_____How Often Refilled_____(see note BELOW) Generic OK?_____

______________________Mg/Mcg _____Form_____#/day_____How Often Refilled_____(see note BELOW) Generic OK?_____

NOTE – Do not list "AS NEEDED" for these medications, list how often the med is refilled **(Mthly, Qtrly, Anly) and** the quantity ordered . **Continue on another page if more room needed.**

Primary Care Dr. Name_________________________________Phone__________________
(Note: Some plans have Dr. networks so we want to check to see if your Dr. accepts various plans)

Specialist Name/Type__________________________________Phone__________________

Specialist Name/Type__________________________________Phone__________________

Specialist Name/Type__________________________________Phone__________________

We will utilize a screen share to review your analysis. Please mark ALL devices you have available:

PC/Laptop Mac iPad iPhone Android None

Return form to HealthCare Benefit Services
Mail: 6638 W. Ottawa Ave, Suite 120, Littleton, CO 80128
Fax: 720-287-7055, Email: info@HBSLTC.com (Email is not a secure form of communication.)
Phone: 303-973-6636 or **800-295-5860**

Disclaimer: Sharing this information with us is strictly voluntary. The information is used to create a more accurate plan analysis based on your specific needs as presented by Medicare's Official Website.