Lifestyle ADVISORS

Health Benefits Planning

Medicare Needs Assessment

Name: DOB

Address: Phone:
County:

Medicare #

Part A: Part B: VA Benefits?

What is your current medicare plan?_____

Supplement $_____ PDP $_____ MAPD $_____ month

Medicines: (pharmacy and cost)

Doctor and Preferred Clinic:

Do you need dental work, hearing aids, glasses, or surgery?

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