



ANDERSON ELDER LAW

206 Old State Rd, Media, PA 19063 T: 610-566-4700 F: 610-566-4702

MEDICARE QUESTIONNAIRE (SINGLE or MARRIED, EACH SPOUSE TO COMPLETE A SEPARATE FORM)

This form is extremely important. Your accuracy and completeness in responding will help me represent you. Bring this form and requested documents with you to our appointment!

Date: _____ File No.: _____

Home Phone No.: _____ Cell Phone No.: _____

Email Address: _____

A. CLIENT DATA:

Full Name: _____

Street Address: _____

Birth Date: _____

Social Security No.: _____

Do you have employer sponsored Drug Coverage? Yes No

If yes, please be sure to provide a copy of your insurance card.

Are you a Veteran? Yes No

Are you enrolled in Tricare? Yes No

If you are/were married, was your spouse a Veteran? Yes No

Are you enrolled in PACE/PACENET? Yes No

If no, please provide a copy of your last year's income tax return.

B. MEDICARE INFORMATION (FROM YOUR MEDICARE CARD):

Effective Date of Enrollment: Part A (Hospital) _____

Effective Date of Enrollment: Part B (Medical) _____

Please bring your Medicare Card, all insurance cards and all prescription cards to your appointment!

C. YOUR PREFERRED PHARMACY:

Name: _____ Phone Number: _____

Location: _____



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D. YOUR MEDICATIONS:

In order to gather this information, you may choose to visit your pharmacy and ask for a print-out of your current prescriptions. Otherwise, you should fill out the chart completely with all your current prescriptions!

NAME OF DRUG (Generic or Drug Name)	DOSAGE (Ex. 10mg)	QUANTITY/Month (Ex. 1 per day = 30)	FREQUENCY OF PRESCRIPTION
			<input type="checkbox"/> Monthly <input type="checkbox"/> Bi-Monthly
			<input type="checkbox"/> Monthly <input type="checkbox"/> Bi-Monthly
			<input type="checkbox"/> Monthly <input type="checkbox"/> Bi-Monthly
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