HEALTH DIRECTIONS
THE CENTER FOR HEALTH INSURANCE PLANNING

1300 Post Road, Suite 100
Fairfield, CT 06824
(203) 255-7700
healthdirections@gmail.com
www.health-directions.com

MEDICARE INSURANCE FORM

PART A - CLIENT INFORMATION

PLEASE COMPLETE THE FOLLOWING PERSONAL INFORMATION			DATE ENTERED:
Name (First / Middle / Last)	☐ Male ☐ Female	Date of Birth	Marital Status ☐ Single ☐ Married ☐ Family ☐ Divorced ☐ Widow(er)
Address (Number & Street)		City / State / Zip Code	
Phone Numbers Day: Eve: Cell:			Email Address
Current Insurance	Date		Referred By

PART B - APPLICANT AND SPOUSE INFORMATION

COMPLETE FOR YOU AND YOUR SPOUSE (IF APPLYING FOR COVERAGE)					
	FIRST NAME	MI	LAST NAME	DATE OF BIRTH	ZIP CODE
APPLICANT					
SPOUSE					

PART C - PHYSICIAN AND HEALTH PROVIDER INFORMATION

LIST THE NAME OF EACH DOCTOR, TYPE, AND TOWN FOR ALL FAMILY MEMBERS							
			FOR OFFICE USE ONLY				
DOCTOR'S NAME	SPECIALTY	TOWN	AETNA	ANTHEM	CTCARE	UHC	WELLCARE
Dr. John Doe	*Internal Medicine*	*Fairfield*					

PART D - PRESCRIPTIONS & MEDICATIONS

LIST CURRENT MEDICATIONS, DOSE, AND FREQUENCY FOR ALL FAMILY MEMBERS												
			FOR OFFICE USE ONLY									
PRESCRIPTION NAME	DOSE	FREQUENCY (Per Day)	AARP	AETNA	ANTHEM	CIGNA	CT CARE	ENVISION Rx	FIRST HEALTH	HUMANA	SILVER SCRIPT	WELL CARE
Lipitor	*10mg*	*1*										

NOTES:

SIGNATURE: _____ **DATE:** _____

REP SIGNATURE: _____ **DATE:** _____