New Client Analysis Form

Name _____

Address _____

_____

Phone (____) _____-_____ Age_____

Notes:

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_____
_____

Current Coverage Type: (MAPD / GAP / EGHP / A&B)

Carrier Name: _____

Copay: PCP____ Spec____ HOSP_____ OUT_____

Monthly Premium: $ _____ PDP: $ _____

Income: IND / Couple $ _____ Monthly

Assets: IND / Couple $ _____

Current Assistance Programs:

MSP (YES / NO) Level_____ LIS (YES / NO) _____

Chronic Plan Eligibility:

(Diabetes / COPD / Cardiovascular / CHF)

Review Questions on Chronic Plan Eligibility Form

Travel: Frequency_____ Location_____ Duration_____

Utilization: (High, Mid, Low)

Extra Benefits (Dental / Vision / OTC / Rides / Hearing / Other)

Rx List

_____
_____
_____
_____
_____
_____
_____

_____
_____
_____

Provider List

_____
_____
_____