Leavitt Group, Inc
INSURANCE

Send completed forms to:

Email: karl@leavittgroupinc.com

FAX: (208)772-6276

Mail: 9030 N Hess St #444, Hayden, ID 83835

Prescription Drug/Physician Questionnaire

Medicare Advantage Plans and Medicare Part D Plans provide insurance coverage for your prescription drugs. Please fill out this form so we may provide you with a personalized Medicare report to help us recommend a plan that best fits your situation. Please list your prescription drugs, doctors, and any other information you feel is important below.

Name: _____ Phone: _____

Address: _____ City: _____

State: _____ County _____ Zip: _____ Email: _____

Current Health Plan: _____ Current Prescription Plan: _____

Preferred Pharmacy: _____ Do you use Mail Order? Yes or No

Are you happy with your current policy? Yes or No Are you Low Income Subsidy? Yes or No

Prescription Name:	Dosage:	Frequency:	Generic Y/N?	Canada Y/N?

Please list your Physicians/Specialty care:

Primary Care: _____ Office Name: _____

Specialist's Name: _____ Office Name: _____

Specialist's Name: _____ Office Name: _____

Are you a snowbird? Yes / No If so – where? _____

Please list any special needs or requests you may have:

_____

_____

Scope of Appointment Confirmation Form

Before meeting with a Medicare beneficiary (or their authorized representative), Medicare requires that Licensed Sales Representatives use this form to ensure your appointment focuses only on the type of plan and products you are interested in. A separate form should be used for each Medicare beneficiary. **Please check what you want to discuss with the Licensed Sales Representative.**

Please indicate the product(s) you agree to discuss by checking the applicable checkbox(es):

- ☐ **Medicare Advantage Plans (Part C) and Cost Plans**
- ☐ **Stand-alone Medicare Prescription Drug Plan (Part D)**
- ☐ **Medicare Supplement (Medigap) Plan**
- ☐ **Dental-Vision-Hearing Products**
- ☐ **Hospital Indemnity Products**

By signing this form, you agree to meet with a Licensed Sales Representative to discuss the products checked above. The Licensed Sales Representative is either employed or contracted by a Medicare plan and may be paid based on your enrollment in a plan. They **do not** work directly for the federal government.

Signing this form **does not** affect your current or future enrollment in a Medicare plan, enroll you in a Medicare plan or obligate you to enroll in a Medicare plan. All information provided on this form is confidential.

Beneficiary or Authorized Representative Signature and Signature Date:

X _____ _____

Signature: **Signature Date:**

If you are the authorized representative, please sign above and print clearly and legibly below:

_____ _____

Authorized Representative's Name: Your Relationship to the Beneficiary:

To be completed by the Licensed Sales Representative (print clearly and legibly):

Licensed Sales Representative Name (First_Last)	Licensed Sales Representative Phone	Licensed Sales Representative ID
Beneficiary Name (First_Last)	Beneficiary Phone (Optional)	Date Appointment will be Completed
Beneficiary Address (Optional)		
Initial Method of Contact	Plan(s) the Licensed Sales Representative will represent during the meeting	
Licensed Sales Representative Signature		

Scope of Appointment documentation is subject to CMS record retention requirements