Medicare Beneficiary Needs Assessment

Personal & Confidential
For Agent Use Only

Date: _____

Client Name:_____

Clover Health

ENROLLMENT PERIOD

☐ AEP ☐ OEP ☐ SEP – Reason:_____

☐ Scope of Appointment (SOA) Completed – Date: _____

CLIENT PROFILE

Client Name – First:_____MI:____ Last:_____
(as it appears on Medicare card)

DOB: _____ Medicare ID #:_____

Part A Effective Date:_____ Part B Effective Date: _____

Spouse Name – First: _____MI:____ Last:_____
(as it appears on Medicare card)

DOB: _____ Medicare ID #:_____

Part A Effective Date:_____ Part B Effective Date: _____

Is there anyone who helps you with your healthcare decisions? ☐ Y ☐ N

If Yes, Name/Relationship: _____

Do you have a healthcare power of attorney (POA)? ☐ Y ☐ N

If Yes, Name: _____

CONTACT INFORMATION

Primary Residence Address

Address:_____City:_____

State: _____ Zip: _____County: _____

Preferred Mailing Address (if different than primary; cannot be P.O. Box)

Address: _____City:_____

State: _____ Zip: _____County:_____

Home Phone: _____Mobile Phone: _____

Email: _____Preferred Method of Contact: _____

Permission to email? ☐ Y ☐ N Permission to text? ☐ Y ☐ N

REVIEW OF CURRENT INSURANCE COVERAGE

Do you/your spouse currently have health coverage? ☐ Y ☐ N

If No, Reason: _____

If Yes, what type of health coverage do you currently have?

- ☐ Employer ○ PPO ○ HMO
- ☐ Private ○ PPO ○ HMO
- ☐ Original Medicare
- ☐ Medicare Advantage ○ PPO ○ HMO
- ☐ Medicare Supplement Insurance
- ☐ Medicare Part D plan
- ☐ TRICARE
- ☐ Federal Employee Health Benefits (FEHB)
- ☐ VA benefits
- ☐ State pharmaceutical assistance program
- ☐ Other: _____

Insurer (If Applicable): _____

Which benefits/services are most important to you?

- ☐ Primary care provider
- ☐ Specialists
- ☐ Prescriptions
- ☐ Hospital
- ☐ Network flexibility
- ☐ Supplemental benefits (dental, vision, hearing)
- ☐ Other benefits (fitness, in-home care, OTC/grocery)
- ☐ Other: _____

REVIEW OF CURRENT HEALTHCARE

Do you currently have a primary care provider?

☐ Y ☐ N If Yes:

Name: _____

Location: _____

Phone #: _____

Do you currently see any specialists?

☐ Y ☐ N If Yes:

Name: _____

Location: _____

Phone #: _____

Name: _____

Location: _____

Phone #: _____

Name: _____

Location: _____

Phone #: _____

Are there any medications you want me to check the formulary for? ☐ Y ☐ N

If Yes, Medication(s):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Leave behind Summary of Benefits: ☐ Y ☐ N

Shared Compliance presentation: ☐ Y ☐ N

Enrolled: ☐ Y ☐ N

If Yes:

Application Date: _____ Effective Date: _____ Plan: _____

Application Confirmation #: _____ Policy ID: _____

Notes:

Clover Health