Medicare Personal Information Sheet

MEMBER INFORMATION

NAME: **DATE OF BIRTH:**

PHONE: **EMAIL:**

MEDICARE CLAIM #:

PART A EFFECTIVE DATE: **PART B EFFECTIVE DATE:**

HOME ADDRESS:

CITY: **STATE:**

ZIPCODE: **COUNTY:**

MY RX LIST

MEDICATION NAME	DOSAGE	QUANTITY	DAY SUPPLY	MAIL ORDER/RETAIL

MY DOCTOR LIST

MY HOSPITAL LIST

DOCTOR NAME	ZIPCODE	PHONE	SPECIALTY	HOSPITAL	ZIPCODE	PHONE

Questions?
Call 1-800-722-7331 to speak with a Medicare Enrollment Specialist.