

2019 Advantage Plan Review Form

Thank you for taking the time to fill out our form. Even if you do not wish to have your coverage reviewed please still complete the "General Information" section and return to us so we can make sure our records are up to date.

General Information

Fill out this section completely.

Full Name (as it reads on your Medicare card): _____
Nick Name (if any): _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
Email Address: _____
Date of Birth: _____

If You Are Happy with Your Current Advantage Plan and want it to Automatically Renew You Can Stop Here

If You Would Like to Look at Other Advantage Plans or Switch from Original Medicare to an Advantage Plan Continue...

Select One:

I take 3 or less prescriptions so I do not need to have a mymedicare.gov account created.
 I have created a mymedicare.gov account and by providing my login information give you permission to access my information to quote my coverage.
My login is: _____ My password is: _____
 I give you permission to create a mymedicare.gov account on my behalf. I understand that I will be provided my login and password created for me.

Sign: _____ Date: _____

Medicare Card Update



Medicare Number: _____
Hospital (Part A) effective date: _____
Medical (Part B) effective date: _____

Continue on the next page

Current Advantage Plan Company: _____

My Plan is a: HMO PPO I Don't Know

Current Medicare Advantage Plan Monthly Premium: _____

Do you have VA benefits available to you? yes no

If you also have Medicaid what is your Medicaid number? _____

Prescriptions

If you created a myMedicare.gov account and filled in your own prescriptions, you do not need to fill out the prescription portion of this form.

Choose One:

I prefer picking up my prescriptions at a pharmacy. I prefer using a mail order service I do not have a preference

What, if any, is/are your preferred pharmacy(s): _____

Important Note: If you take a prescription "as needed" please provide the approximate number of times you fill your prescription each year. We need to know your best estimate on how often you will refill your prescription throughout a calendar year. Double check spelling and dosage on your prescriptions. In addition, please write down the generic name instead of the brand name if that is what you take. Be sure to write down the entire prescription. If there is an ER or other abbreviation after the name that will affect the quote. Incorrect or incomplete information greatly slows down our quoting process and can lead to inaccurate quotes. Thank you in advance for being thorough.

Name (Example: Simvastatin)	Dosage (Example: 40mg tablet)	Frequency (Example: 1x daily)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

(Continue on the next page)

Name (Example: Simvastatin)	Dosage (Example: 40mg tablet)	Frequency (Example: 1x daily)
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		
21.		
22.		
23.		
24.		
25.		

Doctors

List your current doctors' full name, location and their specialty.

Full Name	City or Zip Code Of Office Location	Specialty (primary care, ortho, etc)

(Continue on the next page)

Check the statement that describes your situation:

- My doctors are very important to me so I do not want to switch plans if my doctors are not in network.
- If another plan saves me quite a bit of money or has better coverage for me then I am willing to switch doctors if they are not in network.

When it comes to my Advantage plan I am most concerned about:

Rank the following based on Importance to You when it comes to selecting an Advantage Plan: (1 being most important, 4 being least important)

- Monthly Premium
- Maximum Out of Pocket
- The Ability to Travel outside of the coverage area and receive non-emergency coverage
- Extra Benefits such as Dental/Vision/Hearing/Gym Memberships Etc.

Submitting Your Form:

The Scope of Appointment Form (on the following page) Must be completed and submitted with this form.

To submit you can:

- Scan and Email it to: review@KeysToMedicare.com
- Fax it to: 317-558-9889
- Mail it to: Keys To Medicare
15010 Glenmoor Cir.
Carmel, IN 46033

All Forms Must Be Received Before Thanksgiving to Ensure Your Review Will Be Completed by the December 7th Deadline.

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

Dental-Vision-Hearing Products Hospital

Stand-alone Medicare Prescription Drug Plan (Part D)

Indemnity Products

Medicare Supplement (Medigap) Plan

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:

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

Product Descriptions

Stand-alone Medicare Prescription Drug Plans (Part D)
Medicare Prescription Drug Plan (PDP) — A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private Fee-For-Service Plans, and Medicare Medical Savings Account Plans.
Medicare Advantage Plans (Part C) and Cost Plans
Medicare Health Maintenance Organization (HMO) — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan’s network (except in emergencies).
Medicare HMO Point-of-Service (HMO-POS) — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. HMO-POS plans may allow you to get some services out of network for a higher copayment or coinsurance.
Medicare Preferred Provider Organization (PPO) Plan — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors, providers and hospitals but you can also use out-of-network providers, usually at a higher cost.
Medicare Private Fee-For-Service (PFFS) Plan — A Medicare Advantage Plan in which you may go to any Medicare-approved doctor, hospital and provider that accepts the plan’s payment, terms and conditions and agrees to treat you — not all providers will. If you join a PFFS Plan that has a network, you can see any of the network providers who have agreed to always treat plan members. You will usually pay more to see out-of-network providers.
Medicare Special Needs Plan (SNP) — A Medicare Advantage Plan that has a benefit package designed for people with special health care needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in nursing homes, and people who have certain chronic medical conditions.
Medicare Medical Savings Account (MSA) Plan — MSA Plans combine a high deductible health plan with a bank account. The plan deposits money from Medicare into the account. You can use it to pay your medical expenses until your deductible is met.
Medicare Cost Plan — In a Medicare Cost Plan, you can go to providers both in and out of network. If you get services outside of the plan’s network, your Medicare-covered services will be paid for under Original Medicare but you will be responsible for Medicare coinsurance and deductibles.
Other Health-Related Products
Dental/Vision/Hearing Products — Plans offering additional benefits for consumers who are looking to cover needs for dental, vision, or hearing. These plans are not affiliated or connected to Medicare.
Hospital Indemnity Products — Plans offering additional benefits; payable to consumers based upon their medical utilization; sometimes used to defray copays/coinsurance. These plans are not affiliated or connected to Medicare.
Medicare Supplement (Medigap) Products — Insurance plans that help pay some of the out-of-pocket costs not paid by Original Medicare (Parts A and B) such as deductibles and co-insurance amounts for Medicare approved services.