2024 MEDICARE ADVANTAGE PLAN
REVIEW FORM

Enrollment Starts October 15, 2023

IMPORTANT: Medicare Open Enrollment Ends: December 7, 2023

SPECIAL NOTE: *Reviews are available if this form is complete including your list of medications. Return it to me by fax, email, or by mail in order to get a review. The best way to reach me is by email and not by phone in order to get the reviews back to you. The average drug savings is $300 to $2,000...It's worth completing the form. Please note: Completing this form will not prevent you from enrolling into any plan of your choice for which you are eligible.*

Name: _____ Phone: _____

Street: _____ City/State/Zip: _____

Email: _____ Date of Birth: _____

Name of Current Plan: _____

Did the drug plan meet your needs last year? (Please Check One) ☐ YES ☐ NO

If not, what needs to be improved? _____

_____

Did the medical plan meet your needs last year? (Please Check One) ☐ YES ☐ NO

If not what needs to be improved: _____

_____

Please look at the new changes for 2024 on your medical or drug plan. What changes give you concern?

_____

Name of your pharmacy? _____

Will you mail order drugs? (Please Check One) ☐ YES ☐ NO

If you have medications, you would like me to review, please list them, the dosage, and frequency on the back of this form or include your list.

Name of your doctor(s):

DOCTOR'S NAME	SPECIALTY	CITY AND ZIP CODE

CONTINUED ON NEXT PAGE

LIST OF MEDICATIONS

NAME OF MEDICATION	BRAND	GENERIC	DOSAGE (MG)	NUMBER OF TIMES TAKEN
	☐	☐		_____ Per Day/Month/Year (Circle)
	☐	☐		_____ Per Day/Month/Year (Circle)
	☐	☐		_____ Per Day/Month/Year (Circle)
	☐	☐		_____ Per Day/Month/Year (Circle)
	☐	☐		_____ Per Day/Month/Year (Circle)
	☐	☐		_____ Per Day/Month/Year (Circle)
	☐	☐		_____ Per Day/Month/Year (Circle)
	☐	☐		_____ Per Day/Month/Year (Circle)
	☐	☐		_____ Per Day/Month/Year (Circle)
	☐	☐		_____ Per Day/Month/Year (Circle)
	☐	☐		_____ Per Day/Month/Year (Circle)
	☐	☐		_____ Per Day/Month/Year (Circle)

Please note that your information is held in private and all data is uniformly secured in accordance with the standards set forth in the Health Insurance Portability and Accountability Act.

STATEMENT AND REQUEST FOR CONTACT

I am making the express request for contact by my agent Elizabeth Vipond for her services in reviewing all plans available to me and do not wish to be limited to a review of my current plan.

PRINT NAME: ____

SIGNATURE: ____ **DATE:** ______________

Please return this form by fax at 813-443-1292 or email it to: Betsy@theseniorheathadvisor.com. You can also mail your response to: Elizabeth Vipond, 1209 E. Cumberland Ave. Unit 1903, Tampa, FL 33602.

There are no fees associated with this review. Compensation is based on your enrollment.