Needs Analysis Worksheet

For agent use only!

Spouse Name:_____ Referred by: _____

Spouse DOB:_____

Name: _____ Phone:_____

Address: _____ City: _____ State/Zip: _____

Current health/drug plan name: _____

Other drug coverage such as VA, retirement plan etc.: _____

Preferred pharmacy?_____ Do you use mail order? ☐ Yes ☐ No

Current PCP: _____ Current Specialist: _____

Hospital Preference: _____ DOB:_____

Medicare # _____ ☐ ☐

Part A effective date _____ Part B effective date _____

Do you have any chronic conditions such as Asthma, COPD, Cardiovascular Disease (CVD), Congestive Heart Failure (CHF), Dementia, Diabetes, Hypertension etc? Explain: _____

Would you like information on Low Income Subsidy to assist with the cost of your prescriptions (up to $4000 per year may be available)? ☐ Yes ☐ No

Entered into Excel: ____**Yes** ____ **No** Entered into ACT: ____**Yes** ____**No**

PRESCRIPTION NAME:	**STRENGTH:**	**FREQUENCY:**	**BRAND OR GENERIC:**
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			