HOVIS & ASSOCIATES

De Soto Office	Festus Office	St. Louis Office
120 North Main Street	615A Collins Drive	12660 Lamplighter Square
De Soto, Missouri 63020	Festus, Missouri 63028	Saint Louis, Missouri 63128

Client Name: ______________________________ Date: ______________

Home Phone #: ______________________ Cell Phone #:______________________

Address: ____

City: ______________________ Zip Code: ________ County: __________

E-Mail: ____

Preferred Pharmacy: ______________________________

Please indicate your current prescription medications that you are taking so we can perform a cost analysis.

PLEASE READ

Do you want Hovis & Associates to use the generic form of your medication, if one is available? **Y** **N**

	Prescription Medication	Dosage	How many times a day you take this
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			

	Initials	Date	Drug List ID	Agent
Ran Meds				

*You are not required to provide any private, protected health information (PHI). The above requested information is for use by Hovis & Associates only to help you make an informed plan decision and will not be shared with any third party. You will be providing the PHI voluntarily and without coercion from Hovis & Associates.

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Client Name: ______________________________________ Date of Birth:_________________

Zip Code:___________________ County:______________________

Please answer the following questions so that your health insurance consultation will be as thorough as possible.

- What are your Medicare effective dates? Part A ________________
  (*You will find this on your red, white and blue Medicare card)* Part B_________________
- What is your current coverage? ____
- What hospital do you prefer? ____
- Who is your primary care physician? ____
  (Please indicate first and last name)
- What specialists do you see and their locations?

  Cardiologist:____________________________________Location:____________________
  Endocrinologist: ________________________________ Location: ____________________
  Gastroenterologist: _____________________________ Location: ____________________
  OBGYN: _______________________________________ Location: ____________________
  Psychologist: __________________________________ Location: ____________________
  Pulmonologist: _________________________________ Location: ____________________
  Urologist: _____________________________________ Location: ____________________
  Others: _______________________________________ Location: ____________________
  ____ Location: ____________________

- Are you coming off employer coverage? Y N
  If you answered *yes* are you losing your dental or vision also? Y N
- Are you on Medicaid? Y N
  If you answered *yes*, are you on a spend-down? Y N
  If you answered *yes*, how much per month? $______________
- Are you on a Low Income Subsidy? Y N
- Do you have a Mo RX card for your prescriptions? Y N
- Do you have a Power of Attorney (POA)? Y N
  (If yes, please provide name and phone number below)

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Phone: 800-411-0737 **www.HovisandAssociates.com** **Fax: 636-586-9203**