

NAME: _____

PHONE: _____

ADDRESS: _____

EMAIL: _____

DOB: ____/____/____

HOSPITAL: _____

PCP: _____

SPECIALIST: _____

MEDICATION DOSAGE
& FREQUENCY: _____

PHARMACY: _____

CURRENT MEDICARE PLAN &
TYPE: _____

FOR MEDICAID ONLY:

SPENDDOWN: \$ _____

SS INCOME: \$ _____

MISC. INCOME: \$ _____

VA ONLY:

VA: ____ TRI-C: ____ C-VA: ____

*TruCare
Insurance, LLC*

**FILL OUT CARD INFORMATION
BELOW:**



Name/Nombre

Medicare Number/Número de Medicare

Entitled to/Con derecho a

HOSPITAL (PART A)

MEDICAL (PART B)

Coverage starts/Cobertura empieza

-01-

-01-

MEDICAID ID:

(If applicable)

YES

NO

CONCERNS:

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☐

HOSPITAL COPAYS

☐

☐

LONG/SHORT TERM CARE

☐

☐

CANCER DIAGNOSIS

☐

☐

HOME HEALTH CARE COSTS

☐

☐

DENTAL/VISION

FINAL EXPENSE PLAN: _____

FOR INTERNAL USE ONLY