OCEAN FINANCIAL ASSOCIATES, LLC.

MEDICARE QUESTIONNAIRE

NAME: _____

COMPLETE ADDRESS with zip: _____

COUNTY: _____ PHONE: _____ DOB: _____

MEDICARE #: _____ SS #: _____

MEDICAID #: _____ PAAD #: _____

HOSPITAL PART A: ____ ____ ____ Current Insurance Company: _____

MEDICAL PART B: ____ ____ ____ Current Plan Name: _____

PROPOSED Effective Date: _____ EFFECTIVE DATE: _____

SMOKER: _____ NON-SMOKER: _____ EMAIL ADDRESS: _____

DOCTORS' Names & Addresses	MEDICATIONS: Name, Dosage, Frequency

Preferred Pharmacy: _____ Preferred Hospital: _____

200 Atlantic City Blvd., Suite 4, Beachwood, NJ 08722