

MEDICARE WORKSHEET

Date of Appointment:

Call Zoom In-Person

Name:

Zip Code:

County:

Date of Birth:

Medicare	Hospital	Indemnity	Homecare	Cancer Policy
Year: Plan: MOOP: Benefits:	You pay copays for year _____ Hospital: Skilled Nursing & Rehab: Ambulance:	Recommended Coverage:	Medicare has a 21/day episode PT/OT 28 min/2x a week 1-2 RN visits a week at beginning and end of episode <u>Must be homebound</u> <u>No custodial care</u> Plan A B C	Covers -Your MOOP maximum from column 1 -Recommended 19,000 genome test (Medicare only covers 400 at stage 3 and 4)
Recommended plan for plan year _____	Outpatient Surgery: Therapy (outside home):		Long-Term Care? Yes No RX yearly maximum reimbursement level:	Monthly premium: - GTL Precision cancer plan = \$5,000 lump sum payment and 2 nd payment up \$5,000 with genome testing \$100 for annual wellness check-up
Part B premium: Premium for plan:		Monthly Premium: Premium:	Monthly Premium - RX annualized reimbursement Net cost Month =	Net Cost: (per policy guidelines)
Premium:	Premium:	Premium:	Premium:	Premium:
TOTAL PREMIUM:				