Minnesota Benefit Association
6701 Upper Afton Rd St Paul, MN 55125
651-358-2990

Medicare Needs Analysis form 2025

Member Profile

Name: ______________________ DOB: ______________

Street: ______________________________________

City: ____________ County: ______________ State: ________ Zip: ________

Phone: ______________________________________

Email: ______________________________________

1. Do you currently have Medicare Part A or Part B? Yes No

   Medicare ID #: ______________________________

   1a. Medicare Part A effective date: ______________________

   1b. Medicare Part B effective date: ______________________

2. List your current prescriptions. Please include drug name (generic/brand), dosage in milligrams (MG), tablet or capsules and quantity that you take per month.

Name of Rx	Dosage/MG	Tabs/Caps	Quantity per month

**If necessary, include separate page.*

Please complete and return to Minnesota Benefit Association or bring to your appointment

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Your Current Providers	Yes	No	If yes, complete
4. Do you have a Primary Care Physician (PCP)? Visits in last 12 months: ______			Physician Name: ______ Clinic: ______ City, State: ______
5. Do you currently see a specialist? Visits in last 12 months: ______			Specialist Name: ______ Clinic: ______ City, State: ______
6. Do you have preferred hospital? Visits in last 12 months: ______			Name: ______ State: ______
7. Do you have a preferred pharmacy? Visits in last 12 months: ______			Name: ______ State: ______

**If necessary, include separate page.*

Needs Questionnaire				Yes	No
8. Do you have End Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis (ALS)?					
9. Do you receive any injections/treatments at a Clinic or Hospital?					
9a. Description: ______					
10. Are you willing to look at health plan options that do not include your current provider(s)?					
11. Do you live in a long-term care or skilled nursing facility?					
12. Do you currently receive health or drug coverage through the VA, Union, current or a former employer?					
13. Do you live part-time in another state?					
15a. If yes, how many months of the year?	3 months	6 months	9 months		

Additional Info:

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REMINDER: You must continue to pay your Medicare Part B premiums regardless of which Medicare Supplement or Advantage plan you choose.

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