Medicare Health Plan and Prescription Drug Check Up Form

Step 1: Please update your personal information with us using one of the following options:

Option A
Please complete this Check Up Form entirely & return it by one of the following ways:

- Mail to TLC Senior Solutions, 105 Mead Ave, Meadville, PA 16335
- Email to meadville@tlcinsurancegroup.com
- Drop it off in person at our office

OR

Option B
Please scan the QR code to update your information electronically!

Step 2: Please have these items ready for your appointment:


Medicare Card


Current Insurance Card(s)


This Completed Form

In order to give our staff enough time to process, please complete one of these options as soon as possible, and no later than December 1, 2026.

Full Name: _____ Gender: ◯ Male ◯ Female
First & Last Name

Date of Birth: _____ Email: _____

Physical Address: _____
Street City State Zip Code County

Mailing Address: _____
(if different) *Street City State Zip Code*

Preferred Phone: _____ Alternate Phone: _____
O Home Number O Mobile Number *O Home Number O Mobile Number*

Your Current Plan Information: (e.g. United Health Care Plan G, Aetna Medicare Signature PPO, Wellcare Value RX, etc)

_____

Are you a Veteran? ◯ Yes ◯ No Do you Receive Extra Help or Medicaid? ◯ Yes ◯ No

Do you travel? ◯ Yes ◯ No If yes, for how long? _____

Your Preferred Providers:

Primary Care Physician: _____
First & Last Name

Office Address: _____
Street City State Zip Code

Hospital: _____ Location: _____
City State

Dentist: _____ Location: _____
City State

Optometrist: _____ Location: _____
City State

Please complete both sides of this form. Thank you!

Your Specialists:

Name: ______________________ Address: ______________________
First & Last Name — Street, City, State & Zip Code

Name: ______________________ Address: ______________________
First & Last Name — Street, City, State & Zip Code

Name: ______________________ Address: ______________________
First & Last Name — Street, City, State & Zip Code

Name: ______________________ Address: ______________________
First & Last Name — Street, City, State & Zip Code

Your Prescriptions:

PLEASE NOTE: ONLY THE MEDICATIONS YOU LIST BELOW WILL BE CONSIDERED IN YOUR REVIEW.
Do NOT include vitamins, supplements, or other over-the-counter items. If you need additional space, please use extra paper.

Name of Medication	Check if Brand ONLY:	Dosage	Rx Type	Quantity taken daily?	Check if only As Needed:
***EXAMPLE**:* *Synthroid*	☒	*137 mcg*	☒ Tablet ○ Eyedrops ○ Capsule ○ Cream ○ Insulin ○ Other	Per Day: *1* If not daily, how often? ______	☐
	☐		○ Tablet ○ Eyedrops ○ Capsule ○ Cream ○ Insulin ○ Other	Per Day: ______ If not daily, how often? ______	☐
	☐		○ Tablet ○ Eyedrops ○ Capsule ○ Cream ○ Insulin ○ Other	Per Day: ______ If not daily, how often? ______	☐
	☐		○ Tablet ○ Eyedrops ○ Capsule ○ Cream ○ Insulin ○ Other	Per Day: ______ If not daily, how often? ______	☐
	☐		○ Tablet ○ Eyedrops ○ Capsule ○ Cream ○ Insulin ○ Other	Per Day: ______ If not daily, how often? ______	☐
	☐		○ Tablet ○ Eyedrops ○ Capsule ○ Cream ○ Insulin ○ Other	Per Day: ______ If not daily, how often? ______	☐
	☐		○ Tablet ○ Eyedrops ○ Capsule ○ Cream ○ Insulin ○ Other	Per Day: ______ If not daily, how often? ______	☐
	☐		○ Tablet ○ Eyedrops ○ Capsule ○ Cream ○ Insulin ○ Other	Per Day: ______ If not daily, how often? ______	☐
	☐		○ Tablet ○ Eyedrops ○ Capsule ○ Cream ○ Insulin ○ Other	Per Day: ______ If not daily, how often? ______	☐

Preferred Retail Pharmacies: (1) ______________________ (2) ______________________

Do you use Mail Order Pharmacy? ○ Yes ○ No

Authorization

I am voluntarily providing the information on this form to help select an individual or group Medicare plan. I understand that I am seeking guidance and a personalized recommendation at no cost and with no obligation. I authorize **TLC Senior Solutions** to contact me by phone, email, or mail if needed. The information I've provided will be used only to help identify the Medicare plan that best fits my needs. I also understand I am not required to accept any recommendation. By signing below, I give permission for a licensed agent to contact me regarding my healthcare coverage.

Signature: ______________________ **Date:** ______________