TONKA | FINANCIAL SERVICES
952 746 5110 WWW.TONKAFINANCIAL.COM

Medicare Needs Analysis Form **Date:_____**

Member Profile:

Name: _____

Medicare ID #: _____

Part A Effective Date: _____ Part B Effective Date:_____

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

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

**If necessary, include separate page.*

2. How often do you go to the doctor or see a specialist? ☐ Rarely ☐ Regularly ☐ Frequently

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952.746.5110 office 763.746.2027 fax 888.746.5110 toll free

Your Current Providers	Yes	No	If yes, complete
3. Do you have a Primary Care Physician (PCP)?	☐	☐	Name/Clinic: _____ Address: _____ Phone: _____
4. Do you currently see a specialist?	☐	☐	Name/Clinic: _____ Address: _____ Phone: _____
5. Do you have preferred hospital?	☐	☐	Name/Clinic: _____ Address: _____ Phone: _____
6. Do you have a preferred pharmacy?	☐	☐	Name/Clinic: _____ Address: _____ Phone: _____

**If necessary, include a separate page.*

Needs Questionnaire	Yes	No
7. Do you have End Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis (ALS)?	☐	☐
8. Do you receive any injections/treatments at a Clinic or Hospital?	☐	☐
8a. Description: _____		
9. Are you willing to look at health plan options that do not include your current PCP?	☐	☐
10. Are you willing to look at health plan options that do not include your current specialist	☐	☐
11. Are you willing to look at health plan options that do not include your current hospital?	☐	☐
12. Do you live in a long-term care or skilled nursing facility?	☐	☐
13. Do you currently receive health or drug coverage through the VA, Union, current or a former employer?	☐	☐
14. Do you live part-time in another state?	☐	☐
14a. If yes, how many months of the year? ☐ 3 months ☐ 6 months ☐ 9 months		

Everything on this form is accurate to the best of my knowledge. If there are any changes, I acknowledge that I am to provide updated information to Tonka Financial Services in a timely manner.
Signature or Initial: _____

Disclaimer: Once completed this form may contain Protected Health Information and Personally Identifiable Information. Keep PHI & PII safe, any misuse or unauthorized disclosure may result in civil and criminal penalties.

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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