

## Medicare HMO Plan Worksheet

	Option 1 Medicare HMO HMO Name: _____	Option 2 Medicare HMO HMO Name: _____	Option 3 Medicare HMO HMO Name: _____
Does my family, or regular doctor, participate in this Medicare HMO?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do my specialists who I see regularly, such as my cardiologist, orthopaedic surgeon, or ophthalmologist, participate in this plan?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Specialist 1: _____	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Specialist 2: _____	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Specialist 3: _____	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Does my family, or regular doctor, participate in this Medicare HMO?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
What is the monthly premium?	\$ _____	\$ _____	\$ _____
What is the co-payment for doctor's visits?	\$ _____	\$ _____	\$ _____
What is the maximum paid each year for prescriptions?	\$ _____	\$ _____	\$ _____
What is the deductible for a hospital stay (if any)?	\$ _____	\$ _____	\$ _____
Does my pharmacy participate in this plan?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Does the hospital I use participate in this plan?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Does the plan cover long term care services such as home care?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
HMO phone number to call for more information:	_____	_____	_____
Make notes here regarding prevention and wellness services covered such as flu shots, mammograms, check-ups, cancer screenings, dental visits, eyeglasses and other important information: _____ _____ _____ _____			