

LIST OF DOCTORS – MEDICARE ADVANTAGE PLANS

I authorize an agent with Imagine Insurance Advisors to call me regarding coverage options and that I am volunteering this medical information.

Name: _____

Phone: _____

Signature: _____

Date: _____

Important instructions: Please complete this form in its entirety. Include all doctors you visit or may see. Use one sheet per household member. The bold box on the right is for our office use.

Primary Care Physician:

Full name: _____ Are you willing to change this Dr? Y N

Street office is on: _____ City, state: _____

Specialty: _____

Preferred Hospital:

Additional Doctor:

Full name: _____ Are you willing to change this Dr? Y N

Street office is on: _____ City, state: _____

Specialty: _____

Additional Doctor:

Full name: _____ Are you willing to change this Dr? Y N

Street office is on: _____ City, state: _____

Specialty: _____

Additional Doctor:

Full name: _____ Are you willing to change this Dr? Y N

Street office is on: _____ City, state: _____

Specialty: _____

Additional Doctor:

Full name: _____ Are you willing to change this Dr? Y N

Street office is on: _____ City, state: _____

Specialty: _____

If you have more doctors, write them on the back and check this box... []

Date checked:		

Please return this doctor list, your medication list and Scope of Appointment form to:

Mail: Imagine Insurance Advisors
3036 Breckenridge Ln, Ste 101
Louisville, KY 40220

Fax: (502) 749-7700
Email: AMHarris@ImagineInsAdv.com
Phone: (502) 742-4979

