Willamette Valley Benefits, Inc.

Medicare Review Form

Name:_____ DOB:_____

Preferred Effective Date:_____

Address:_____ APT #/Suite#:_____

_____ County:_____

Phone:_____

Current Insurance Plan:_____

Preferred Hospital: _____

Preferred Pharmacy: _____

By Returning this form completed, you are agreeing to have a representative of Willamette Valley Benefits, Inc. contact you regarding the information you provided.

In the next few lines please provide a list of your doctors & their phone numbers (if available)

Doctor's Name	Doctor's Phone Number

Prescriptions	Dosage	Per Day

Please return to:

Willamette Valley Benefits, Inc.
6400 SE Lake Road, Suite 155
Portland, OR 97222

Phone: 503-659-5566
Toll Free: 1-888-944-4644
Fax: 503-659-5992

How Did You Hear about Willamette Valley Benefits? _____

If already a client of Willamette Valley Benefits, Inc., who is your Insurance agent?_____