



**Bernhard** Insurance Group

3231 Central Park West  
Suite 100  
Toledo, Ohio 43617  
419.474.8340 p  
866.505.8622 fax

**Medicare Insurance Quote Review**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_ Tobacco User: Yes No

Zip Code: \_\_\_\_\_ County \_\_\_\_\_

Email address: \_\_\_\_\_

**Physicians / Facilities you would like access to:**

Doctor/Facility: \_\_\_\_\_ Specialty \_\_\_\_\_ Location \_\_\_\_\_

Doctor/Facility: \_\_\_\_\_ Specialty \_\_\_\_\_ Location \_\_\_\_\_

Doctor/Facility: \_\_\_\_\_ Specialty \_\_\_\_\_ Location \_\_\_\_\_

Doctor/Facility: \_\_\_\_\_ Specialty \_\_\_\_\_ Location \_\_\_\_\_

**Prescription List (Please list the name on your bottle as it might be a generic):**

Pharmacy you would like to use: \_\_\_\_\_

Name \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_

Name \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_

Name \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_

Name \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_

Name \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_

Name \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_

Name \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_

Name \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_

Name \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_

Please return form to Kirk Bernhard [kirk@bernhardinsurance.com](mailto:kirk@bernhardinsurance.com) or  
Marie Fritsch [marie@bernhardinsurance.com](mailto:marie@bernhardinsurance.com): fax to 866.505.8522