ACTION REQUEST FORM FOR INSURANCE REVIEW

Amber Star Insurance

Phone: (714) 735-7110 Email to: amber@beachcityhealthinsurance.com
Fax to: (714) 908-0417

Mail to: Amber Star Insurance, 6525 Houston Street, Buena Park, CA 90620

Personal Contact Information

Name: _____ **Date of Birth:** _____

Address: _____ **City:** _____ **Zip:** _____

Phone: _____ **Best Time to Call:** _____

eMail: _____ **Tobacco User: (Yes/No)** _____

Medicare MBI #: _____ **Part A Date** _____ **Part B Date:** _____

Have a Medicare.gov Account: Yes ___ No ___ Password: _____ **UserName:** _____

How would you like us to contact you: Phone Call: _____ **eMail:** _____ **Mailed:** _____

Current Medical Information

Preferred Physician: _____ **Medical Group:** _____

Hospital: _____ **Current Med Supl Plan:** _____

Pharmacy Name/Address: _____ **Mail Order: (Yes___/No___)**

Current HMO Plan: _____ **Current RX Plan:** _____

Special Needs: (ex. Diabetes Type 1) _____

My Medication Information

Current Medication **EXACT** Name off Rx bottle and Type (Ex: Tab, Capsule, Cream, Gel)	**Dosage** (Ex: 10 mg)	**Frequency** (Ex: 1x, 2x day or 90 per month)	**If Drug is Name *Brand* Is *Generic* OK** Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No

Client is responsible for providing correct Rx information and verifying it once quotes are created. All information will be kept confidential.

❖ **Estimates calculated by www.Medicare.gov and are subject to change without notice.**

INTERNAL USE ONLY: Received: _____ SOA Rcvd: _____ ACT: _____

Quote ID # / Password Date: _____ Quote Sent: _____