

# Insurance Information Organizer

*Your Complete Healthcare Coverage Binder*



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## Quick Reference Dashboard {#dashboard}

### My Coverage at a Glance

Coverage Type	Have It?	Company	Policy #	Phone
Medicare Part A	<input type="checkbox"/> Yes	Medicare	_____	1-800-633-4227
Medicare Part B	<input type="checkbox"/> Yes	Medicare	_____	1-800-633-4227
Medicare Advantage	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____
Part D (Drugs)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____
Medigap	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____
Dental	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____
Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____
Hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____

### Monthly Premium Summary

- **Part B:** \$ \_\_\_\_\_
- **Part D:** \$ \_\_\_\_\_
- **Medigap:** \$ \_\_\_\_\_
- **MA Plan:** \$ \_\_\_\_\_
- **Other:** \$ \_\_\_\_\_



- **TOTAL:** \$ \_\_\_\_\_
- 



## **Medicare Original (Part A & B) {#medicare-original}**

### **Part A - Hospital Insurance**

**Medicare Number:** \_\_\_\_\_

**Effective Date:** \_\_\_\_\_

**Premium:** [ ] \$0 (40+ quarters) [ ] \$ \_\_\_\_\_ per month

#### **What's Covered:**

- ✓ Inpatient hospital stays
- ✓ Skilled nursing facility care
- ✓ Hospice care
- ✓ Home health services

#### **2025 Costs:**

- **Hospital Deductible:** \$1,676 per benefit period
- **Days 1-60:** \$0 coinsurance
- **Days 61-90:** \$419 per day
- **Days 91+:** \$838 per "lifetime reserve day"

### **Part B - Medical Insurance**

**Effective Date:** \_\_\_\_\_

**Monthly Premium:** \$ \_\_\_\_\_ (Standard: \$185 for 2025)

**Annual Deductible:** \$240

#### **What's Covered:**

- ✓ Doctor visits
- ✓ Outpatient care
- ✓ Preventive services
- ✓ Durable medical equipment
- ✓ CGM devices (Peak Medical!)

#### **My Part B Costs:**

- **After deductible:** 20% of Medicare-approved amount
- **Preventive services:** \$0



- Clinical lab tests: \$0

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## Medicare Advantage (Part C) {#medicare-advantage}

Skip this section if you have Original Medicare + Medigap

Plan Name: \_\_\_\_\_  
Company: \_\_\_\_\_  
Member ID: \_\_\_\_\_  
Group Number: \_\_\_\_\_  
Customer Service: \_\_\_\_\_  
Nurse Hotline: \_\_\_\_\_

### Plan Details

Plan Type: ☐ HMO ☐ PPO ☐ HMO-POS ☐ PFFS

Primary Doctor Required: ☐ Yes ☐ No

PCP Name: \_\_\_\_\_

PCP Phone: \_\_\_\_\_

### Coverage & Costs

Service	In-Network	Out-of-Network
Doctor Visit	\$ _____	\$ _____
Specialist	\$ _____	\$ _____
Emergency Room	\$ _____	\$ _____
Urgent Care	\$ _____	\$ _____
Hospital Stay	\$ _____	\$ _____
Maximum Out-of-Pocket	\$ _____	\$ _____

### Extra Benefits

- ☐ Dental - Coverage: \_\_\_\_\_
- ☐ Vision - Coverage: \_\_\_\_\_
- ☐ Hearing - Coverage: \_\_\_\_\_
- ☐ Fitness - Benefit: \_\_\_\_\_
- ☐ OTC Items - Amount: \$ \_\_\_\_\_

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## Medicare Part D (Prescription) {#part-d}



Plan Name: \_\_\_\_\_  
Company: \_\_\_\_\_  
Member ID: \_\_\_\_\_  
RxBin: \_\_\_\_\_  
RxPCN: \_\_\_\_\_  
RxGrp: \_\_\_\_\_  
Customer Service: \_\_\_\_\_

## 2025 Plan Costs

- Monthly Premium: \$ \_\_\_\_\_
- Annual Deductible: \$ \_\_\_\_\_
- Preferred Pharmacy: \_\_\_\_\_
- Mail Order Pharmacy: \_\_\_\_\_

## Out-of-Pocket Tracker

Remember: \$2,000 maximum for 2025!

### Month Amount Spent Running Total

Jan	\$ _____	\$ _____
Feb	\$ _____	\$ _____
Mar	\$ _____	\$ _____
Apr	\$ _____	\$ _____
May	\$ _____	\$ _____
Jun	\$ _____	\$ _____

## My Medications

### Medication Tier Copay 90-Day?

_____	_____	\$ _____	<input type="checkbox"/> Yes
_____	_____	\$ _____	<input type="checkbox"/> Yes
_____	_____	\$ _____	<input type="checkbox"/> Yes
_____	_____	\$ _____	<input type="checkbox"/> Yes



## Medigap/Supplement Insurance {#medigap}

Skip if you have Medicare Advantage

Company: \_\_\_\_\_  
Policy Number: \_\_\_\_\_



Plan Letter: [ ] A [ ] B [ ] C [ ] D [ ] F [ ] G [ ] K [ ] L [ ] M [ ] N

Customer Service: \_\_\_\_\_

Monthly Premium: \$ \_\_\_\_\_

## What My Plan Covers

Medicare Costs	Plan Pays	I Pay
Part A Deductible	_____ %	_____ %
Part A Coinsurance	_____ %	_____ %
Part B Deductible	_____ %	_____ %
Part B Coinsurance	_____ %	_____ %
Part B Excess	_____ %	_____ %
Foreign Travel	_____ %	_____ %

## Annual Rate Increase History:

- 2023: \_\_\_\_\_ %
- 2024: \_\_\_\_\_ %
- 2025: \_\_\_\_\_ %



## Other Insurance {#other-insurance}

### Dental Insurance

Company: \_\_\_\_\_

Policy #: \_\_\_\_\_

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

Annual Maximum: \$ \_\_\_\_\_

### Vision Insurance

Company: \_\_\_\_\_

Policy #: \_\_\_\_\_

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

Exam Frequency: \_\_\_\_\_

### Long-Term Care Insurance

Company: \_\_\_\_\_

Policy #: \_\_\_\_\_



**Daily Benefit:** \$ \_\_\_\_\_  
**Benefit Period:** \_\_\_\_\_

## Other Coverage

**Type:** \_\_\_\_\_  
**Company:** \_\_\_\_\_  
**Policy #:** \_\_\_\_\_  
**Purpose:** \_\_\_\_\_

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## Provider Directory {#providers}

### Primary Care

**Doctor:** \_\_\_\_\_  
**Practice:** \_\_\_\_\_  
**Phone:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**After Hours:** \_\_\_\_\_

### Specialists

#### Endocrinologist/Diabetes:

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

#### Cardiologist:

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

#### Eye Doctor:

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

#### Podiatrist:

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

#### Other:

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

### Pharmacy



**Primary Pharmacy:** \_\_\_\_\_  
**Phone:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**24-Hour Pharmacy:** \_\_\_\_\_

### Medical Equipment (DME)

**CGM Supplier:** Peak Medical Supplies  
**Phone:** 888-649-5705  
**Other DME:** \_\_\_\_\_  
**Phone:** \_\_\_\_\_



## Annual Coverage Timeline {#timeline}

### 2025 Important Dates

#### Birthday Rule Dates (Medigap)

- My Birthday: \_\_\_\_\_
- 30 days before: \_\_\_\_\_
- 30 days after: \_\_\_\_\_

#### Medicare Dates

- Open Enrollment: Oct 15 - Dec 7
- MA Open Enrollment: Jan 1 - Mar 31
- My Plan Renews: \_\_\_\_\_

### Annual Healthcare Schedule

Month	Task	Completed
January	Review new benefits	[ ]
February	Schedule preventive exams	[ ]
March	Dental cleaning #1	[ ]
April	Vision exam	[ ]
May	Review Part D medications	[ ]
June	Mid-year coverage check	[ ]
July	Hearing test	[ ]
August	Dental cleaning #2	[ ]
September	Flu shot	[ ]
October	Compare plans for next year	[ ]



Month	Task	Completed
November	Make plan changes	[ ]
December	Meet deductibles?	[ ]

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## Emergency Wallet Cards {#emergency-cards}

### Card 1: Medical Emergency (Cut Out)



#### ----- EMERGENCY MEDICAL INFORMATION

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

DOB: \_\_\_\_\_

Blood Type: \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_

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

**Medicare #:** \_\_\_\_\_

**Part D Plan:** \_\_\_\_\_

**Medigap/MA:** \_\_\_\_\_

**Medications:** \_\_\_\_\_

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**Allergies:** \_\_\_\_\_

**Conditions:** \_\_\_\_\_



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### Card 2: Insurance Info (Cut Out)



#### ----- INSURANCE INFORMATION

**Medicare:** \_\_\_\_\_

1-800-MEDICARE

**Part D/Drugs:** \_\_\_\_\_


ID: \_\_\_\_\_

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



**Supplement/MA:** \_\_\_\_\_  
**ID:** \_\_\_\_\_  
**Phone:** \_\_\_\_\_

**Doctor:** \_\_\_\_\_  
**Phone:** \_\_\_\_\_

**Pharmacy:** \_\_\_\_\_  
**Phone:** \_\_\_\_\_  
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## **Important Documents Checklist {#documents}**

### **Keep in This Binder:**

- ☐ Medicare card (copy)
- ☐ Insurance cards (copies)
- ☐ Summary of Benefits
- ☐ Evidence of Coverage
- ☐ Formulary (drug list)
- ☐ Provider directory
- ☐ Premium statements
- ☐ Explanation of Benefits (EOBs)

### **Keep in Safe/Fireproof Box:**

- ☐ Original Medicare card
- ☐ Insurance policies
- ☐ Power of attorney
- ☐ Healthcare proxy
- ☐ Living will
- ☐ HIPAA releases

### **Annual Updates Needed:**

- ☐ Beneficiary information
  - ☐ Emergency contacts
  - ☐ Medication list
  - ☐ Provider information
  - ☐ Insurance changes
  - ☐ Phone numbers
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## Notes & Questions Section

### Questions for Open Enrollment:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

### Changes to Make:

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### Important Notes:

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## Quick Phone Directory

**Medicare:** 1-800-MEDICARE (1-800-633-4227)

**Social Security:** 1-800-772-1213

**My Pharmacy:** \_\_\_\_\_

**My Doctor:** \_\_\_\_\_

**Emergency:** 911

### Family Contacts:

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

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

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

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