Intake for Vermont SMP

Issues and Inquiries

Caller Name if other than Beneficiary

Caller Contact Number

Relationship to Beneficiary

- ☐ *Agency Referral*
- ☐ *Friend*
- ☐ *NA- No beneficiary info*
- ☐ *Other Relative*
- ☐ *Parent*
- ☐ *Child*
- ☐ *Medical Provider*
- ☐ *Other*
- ☐ *Paid Caregiver*
- ☐ *Spouse*

How did you hear about us?

- ☐ *Agency Referral*
- ☐ *Mailing/Brochure*
- ☐ *Other*
- ☐ *Friend/Family*
- ☐ *Media (PSA, ad, newspaper, radio, etc)*
- ☐ *Presentation/Fair*
- ☐ *Web search*

Beneficiary Info- Use View/Edit If Already Entered

**First Name* | *Middle Initial* | **Last Name*

Address | *Apt./Suite*

ZipCode

E-Mail

DOB | *SSN*

Gender | *Age Range* | *Home Phone*

Marital Status

- ☐ *Common Law*
- ☐ *Domestic Partner*
- ☐ *Separated*
- ☐ *Widowed*
- ☐ *Divorced*
- ☐ *Married*
- ☐ *Single*

Medicare or Medicaid Number

Race/ Ethnicity | *Primary Language*

DATE, THEN ENTER ISSUE Below

Provider

Provider Address

Phone # *Dates of Service*

- ☐ *EOMB Explanation of Medical Benefits*
- ☐ *Bills or Statements*
- ☐ *Medicare Summary Notice*
- ☐ *Consent Form*

- ☐ *Medicare A*
- ☐ *Medicare B*
- ☐ *Prescription Drug Plan*
- ☐ *Medicare Advantage*
- ☐ *Durable Medical Equipment*
- ☐ *Medicaid Fraud Unit*

Send all documentation to: VT SMP Director, by email: anita@vermontelders.org
by mail: COVE, P.O. Box 1276, Montpelier, VT 05601
by fax: 802/229-0156