Medicare Prescription Drug Plan Worksheet

1. What is your name as it appears on your Medicare Card?

_____

2. What is your Medicare Claim Number?

_____

What is your date of birth? _____ / _____ / _____

Do you receive:

Social Security 'Extra Help' to pay for your drug plan?

☐ yes ☐ no

Help to pay for Part B premiums?

☐ yes ☐ no

☐ Medicaid ☐ Long Term Care ☐ HCBS Services

Do you have any of the following:

☐ VA; ☐ Federal Retiree Health Benefits;

☐ TRICARE Insurance; ☐ Union Coverage;

☐ Former Employer Retiree Health Insurance;

☐ Supplemental/Medigap/Plan 65

What county do you live in?_____

Phone Number _____

Permanent Address:

Address _____

City, State Zip _____

Mailing Address if Different:

Address _____

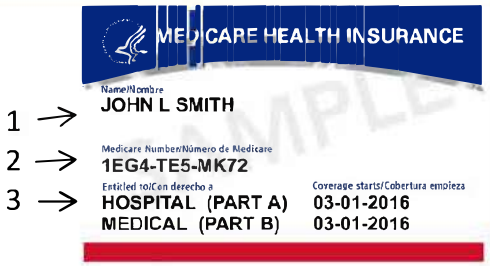
City, State Zip _____

I would like Part D to be: ☐ Billed to Me ☐ Taken from Social Security

I would like to receive Large Print Materials: ☐ Yes ☐ No

Current Pharmacy: _____

Other Pharmacies to check:_____



Please Enter Prescription Drugs on Back

For SHICK Counselor Use:

Date: _____

Counselor: _____

Enrolled: ☐ yes ☐ no

Deduct from Social Security?

☐ yes ☐ no

Compare Last Year? _____

Current Plan: _____

Current Plan OOP: _____

New Plan: _____

New Plan OOP: _____

Savings: _____

Time: _____

Understand Using Plan ☐ yes ☐ no

Understand Estimated Annual Cost

☐ yes ☐ no

Date Reported to SHIP: _____

MyMedicare UserID: _____

Password: _____

Please list **PRESCRIPTION** medicines ONLY, no over-the-counter.
Please Print Clearly.

Drug Name Please print clearly and do not use abbreviations.	Dosage (#mg/pill)	Amount Taken Per Day	How Often Filled (90 Days, 30 days)

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