

decision for yourself.



Medicare Part D Prescription Plan Worksheet



Toll Free: 1-877-801-0044 Local: 1-931-379-2927 FAX: 931-379-2685 or Email: sctn.ship@sctdd.org

If you would like to have a free **2023** Part D Insurance Plan or Medicare Advantage Plan **Comparison** done to check your prescription Costs, fill out both sides of this form. We <u>cannot</u> do a comparison without <u>all</u> of this information. Please complete and return this form by Sept 30, 2022. Comparisons will be mailed out after Oct 15th.

Mail to: SHIP/SMP, 101 Sam Watkins Blvd, Mt Pleasant, TN 38474; FAX: 931-379-2685 or Email: sctn.ship@sctdd.org

ppointments being made.	y Senior Center. Completed forms mus	
Name:	Date of Birth:/	
[Please provide your name as it appears on your Medicare	· Card]	
Address:		=== - X
[Please provide the address and zip code you have on file	with Social Security]	
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Phone:Coun	ty:	
	ZOV.	HEALTH INSURANCE
SN Number:	Name Mombre	EAETHIOGRAPH
mail address:	JOHN L SMITH	
Vhat is your Medicare Claim Number?	Nedicare Number Número de Medica 1EG4-TE5-MK72	
	PART A	03-03-2016 03-03-2016
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vitat is your effective date for Part A: Part B:	PARTE	
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Medicare Advantage Plan (name) MedicaidEmployer/Union Group Health Plan	Medicare.gov Account already we need if your account info to you with your confew days after the account is created. If YesNo If yes, check any that appropriateFederal Employee Health Benderigap/Medicare Supplement, Medigap/Medicare Supplement, private ty with financial assistance, in whole or in part, through from the US Administration for Community Living, De	ed your Inparison. You will I you cancel the account Oly: Defit Plan ent e, etc.) In grant numbers pt of Health & Human Service

I am interested in learning about Medicare present Medicare Stand-alone Prescription Dru coverage you want if you want to stay in Origin	g Plans (Part D) - Off	ers prescription drug coverage onl	y. This is the
☐ Medicare Advantage Plans—Offers cover you may have provider restrictions.	rage for your hospital	and medical care as well as prescri	ption drugs;
□ Both			
Have you applied for Low Income "Extra He If you make less than \$1,719 per month, or \$2,309	elp" assistance? as a couple, you may o	Yes No Qualify for assistance with your pres	cription drugs.
Would you like SHIP to assist you in applying	g for Extra Help? Y	Yes □ No □	
Please provide us with information about you or attach a print out from your pharmacy.		oharmacy. Please complete the ch	nart below
I use this pharmacy(s) to have my prescription. For Diabetic Medications or any medication. List number of vials or pens or inhalers, etc. y column. If you take the Generic—put the Generic is a large difference in the cost.	s that do not come in you use per month. I	Oo Not list as needed in the quant	tity and name
NAME OF DRUG	STRENGTH	Quantity per Month	
Example: Lipitor	Example: 20 mg	Example: 30 or one per day	
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Office use only		<u>.</u>	
Username:	Password:		for MyMed

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