

Medicare Part D Prescription Plan Worksheet Toll free: 1-877-801-0044

Local: 931-379-2927



The following questionnaire provides the necessary information that SHIP/SMP volunteers and staff need to prepare a comparison report. Once you have completed the form, please mail to:

SHIP/SMP, 101 Sam Watkins Blvd, Mt Pleasant, TN 38474 or Fax: 931-379-2685

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Name:	Date o	f Birth: /	/_	
Name:	our Medicare Card)			_
Address:	have on file with CSA			
(Tlease provide the address and 21p code you	ACCINIVE OIT INC.) :		
City:	State:	Zip:_		
		1		
Phone:	County:_			_
	2			
SSN if different than Medicare Nu				
Email address:	-			
What is your Medicare Claim N	umber?	*		
			MEDICARE	HEALT
			1-800-MEDICAR	E ASSIS
What is your effective date for N	Medicare Part A?		DE BENEFICIARY E DOE	1E (1-800-63)
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What is your effective date for N	Medicare Part B?	IS ENT	PITAL PART	EFECTIVE DATE AP 07- B) 07- C CLAIMS FOR NEFITS TO THIS
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What is your effective date for N Do you currently have insurance coverage If yes, check any that apply:		IS ENT	PITAL PART	
Do you currently have insurance coverage If yes, check any that apply:		S ENT HOS ME SIGN [®] HERE	PITAL (PARE DICAL) (PART DO NOT SENI MEDICARE BE	
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Do you currently have insurance coverage If yes, check any that apply:	ge for prescriptions?	Yes	PITAL (PARE PART DO NOT SENI MEDICARE BE	
Do you currently have insurance coverage If yes, check any that apply: Medicare Part D Plan (name) Medicare Advantage Plan (name) Medicaid Employer/Union Group Health Plan	ge for prescriptions?	Yes	PITAL (PARE PART DO NOT SENI MEDICARE BE	
Do you currently have insurance coverage If yes, check any that apply: Medicare Part D Plan (name) Medicare Advantage Plan (name) Medicaid Employer/Union Group Health Plan Federal Employee Health Benefit Plan	ge for prescriptions?	Yes	PITAL (PARE PART DO NOT SENI MEDICARE BE	
Do you currently have insurance coverage If yes, check any that apply: Medicare Part D Plan (name) Medicare Advantage Plan (name) Medicaid Employer/Union Group Health Plan	ge for prescriptions?	Yes	PITAL (PARE PART DO NOT SENI MEDICARE BE	

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I am interested in learning about	Medicare prescription drug coverage as	vailable through:
☐ Medicare Stand-alone Pres coverage you want if you wa	cription Drug Plans (Part D) - Offers nt to stay in Original Medicare and kee	prescription drug coverage only. This is the pyour Medicare Supplement Plan.
 Medicare Advantage Plans you may have provider restrict 	—Offers coverage for your hospital and	d medical care as well as prescription drugs;
□ Both		
Have you applied for Extra He	elp assistance? Yes No	
Would you like SHIP to assist	you in applying for Extra Help? Ye	s 🗆 No 🗆
Please provide us with information al any other additional information. NAME OF PHARMACY YO	U USE (REQUIRED) :	may attach a printout from your pharmacy or
r		ations – list number of vials or pens per month
NAME OF DRUG	STRENGTH	Quantity per Month
Example: Lipitor	Example: 20 mg.	Example: 30 or one per day
1.		
2.		
3.		
4.		
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18.		
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22.		
(Office Use Only) Drug ID:	Password Date:	