Date: ___/___/_____

Medicare Part D
Prescription Plan Worksheet

1-877-801-0044

www.tnmedicarehelp.com

The following questionnaire provides the necessary information that SHIP volunteers and staff need to prepare a comparison report . Once completed, send to TN SHIP , Andrew Jackson Bldg. 9th Floor, 502 Deaderick St., Nashville, TN 37243. You will receive a personalized report in the mail regarding the top two most affordable plans.

Name:_____ Date of Birth:___/___/_____
(Please provide your name as it appears on your Medicare Card)

Address:_____
(Please provide the address and zip code you have on file with SSA)

City:_____ State:_____ Zip:_____

Phone:_____ County:_____

SSN if different than Medicare Number:_____-_____-_____

Email Address: _____

What is your Medicare Claim Number?

☐☐☐ ☐☐ ☐☐☐☐ ☐☐☐

What is your effective date for Medicare Part A?

☐☐ ☐☐ ☐☐☐☐

What is your effective date for Medicare Part B?

☐☐ ☐☐ ☐☐☐☐

Do you currently have insurance coverage for prescriptions? ☐ Yes ☐ No
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
- ☐ TRICARE for Life
- ☐ Veteran's Administration
- ☐ Medigap/Medicare Supplement
- ☐ Other_____(retirement, private, etc.)

I am interested in learning about Medicare prescription drug coverage available through:

☐ **Medicare Stand-alone Prescription Drug Plans (Part D) -** Offers prescription drug coverage only. This is the coverage you want if you want to stay in Original Medicare and keep your Medicare Supplement Plan.

☐ **Medicare Advantage Plans**—Offers coverage for your hospital and medical care as well as prescription drugs; you may have provider restrictions.

☐ **Both**

Have you applied for Low Income "Extra Help" assistance? **Yes** ☐ **No** ☐

Would you like SHIP to assist you in applying for Extra Help? **Yes** ☐ **No** ☐

Do you prefer plans with:

☐ **Maximum deductible (Sometimes plans with deductibles are cheapest for the year)**
☐ **Reduced to zero deductible**
☐ **Doesn't matter**

Please provide us with information about your prescriptions and pharmacy. You may attach a printout from your pharmacy or any other additional information. If no attachment available, please complete the chart below.

I prefer to have my prescriptions filled at this pharmacy:_____

Do you prefer mail order? ☐ **Yes** ☐ **No**

NAME OF DRUG	STRENGTH	Quantity per Month
Example: Lipitor	*Example: 20 mg.*	*Example: 30 or one per day*
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		

Drug ID:_____ Password Date:_____
(Office use only)