

## Medicare Part D Prescription Plan Worksheet 1-877-801-0044 www.tn.gov/aging/

The following questionnaire provides the necessary information that SHIP volunteers and staff need to prepare a comparison report . Once completed, please send to TN SHIP, Andrew Jackson Building, 502 Deaderick Street, 9th Floor, Nashville, TN 37243. You may also fax the form to (615) 741-3309 or email it to tn.ship@tn.gov. You will receive a personalized report in the mail regarding the most affordable plans in your area. TN SHIP does not endorse any Medicare Advantage or Part D Prescription Drug Plan.

Name:(Please provide your name as it appears on your Me		th:/	/	
	•			
Address:(Please provide the address and zip code you have o	on file with SSA)			
City:	State:	Zīp:		
Phone:	County:			
Email Address:				
Please choose how you would like your Med	icare Plan Compai	rison:		
Option 1—Personalized Search for av	vailable plans tailo	red to you		
MyMedicare.gov login info: (I	If you have already	created an	account)	
Username :	Password:			
Option 2—No MyMedicare.gov acco	ount, but still want	plans tailore	ed to you?	
TNSHIP can set up your account wit	h a <b>temporary</b> pa	ssword.		
Medicare Number			MEDICARE HEALTH I	NSURANCE
			Name/Nombre JOHN L SMITH	
Part A Effective Date:				starts/Cobertura empieza
Part B Effective Date:				1-2016
Do you currently have insurance coverage for pres If yes, check any that apply:	criptions? Yes	1	No	
Medicare Part D Plan (name)  Medicare Advantage Plan (name)	DIGADE 6 1 'C			
Employer/Union Group Health Plan	RICARE for Life eteran's Administra Iedigap/Medicare St			

I am interested in learning about Medica	are prescription art	ig coverage available	tnrougn:
Medicare Stand-alone Prescripticoverage you want if you want to start			iption drug coverage only. This is the edicare Supplement Plan.
Medicare Advantage Plans—Off you may have provider restrictions		our hospital and medi	cal care as well as prescription drugs;
□ Both			
Have you applied for Low Income "E If you make less than \$1,581 per month, or			
Would you like SHIP to assist you in a	applying for Extr	a Help? Yes □	No $\square$
Please provide us with information about attach a print out from your pharmacy		otions and pharmacy	. Please complete the chart below
I prefer to have my prescriptions filled	l at this pharmac	y (s):	
Do you prefer mail order? Yes 🗆	$_{\mathbf{No}}$		
Do you prefer a □30 day supply or	a □ 90 day supp	oly	
		•	
NAME OF DRUG	Generic/Brand	STRENGTH/	Quantity per Month
Example: Lipitor	Atorvastatin Cal- cium	Example: 20 mg	Example: 30 or one per day