Date: _____

Medicare Part D Prescription Plan Worksheet

I prefer to receive my comparison by:

☐ *MAIL* ☐ *PHONE* ☐ *EMAIL*

This questionnaire provides the necessary information that SHIP volunteers and staff need to prepare a comparison report. Once your completed form is received by us, we will send you a personalized report regarding the most affordable plans in your area.
TN SHIP does not endorse any Medicare Advantage or Part D Prescription Drug Plan.

Please return to: TCAD, TN SHIP, 502 Deaderick Street, 9th Floor, Nashville, TN 37243; Fax: (615) 741-3309; Email: tn.ship@tn.gov

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: _____

Email Address: _____
(If you prefer an email response be sure to include an email you check often)

Please choose how you would like your Medicare Plan Comparison:

☐ Option 1—Personalized Search for available plans tailored to you

MyMedicare.gov login info: (If you have already created an account)

Username : _____ Password: _____

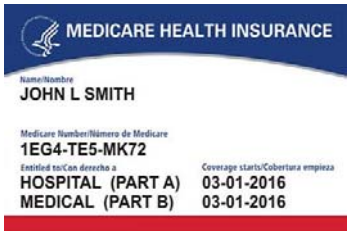
☐ Option 2—No MyMedicare.gov account, but still want plans tailored to you?

TNSHIP can set up your account with a **temporary** password.

Medicare Number: ☐☐☐☐ ☐☐☐ ☐☐☐☐

Part A Effective Date: ☐☐ ☐☐ ☐☐☐☐

Part B Effective Date: ☐☐ ☐☐ ☐☐☐☐



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
☐ Other (retirement, private, etc.) _____
☐ TRICARE for Life
☐ Veteran's Administration
☐ Medigap/Medicare Supplement

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**

If you make less than $1,615 per month, or $2,175 as a couple, you may qualify for assistance with your prescription drugs.

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

Please provide us with information about your prescriptions and pharmacy. Please complete the chart below

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

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

Is your prescription written for: ☐ **30 day supply** ☐ **90 day supply** ☐ **Both/Other?** *Please make note in the Quantity Per Month column below.*

NAME OF DRUG	Generic ok? Y/N	Strength/Dosage	Quantity Per Month
Example: Lipitor	*no*	*Example: 20 mg*	*Example: 30 or one per day*

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