



Medicare Part D Prescription Plan Worksheet



This worksheet provides the necessary information that SHIP volunteers and staff need to prepare a personalized comparison report for you. *TN SHIP does not endorse any Medicare Advantage or Part D Prescription Drug Plan. Any information provided on this form will not be sold, shared, or used for any other purpose besides providing you with a plan comparison.*

**Please remit to: TCAD, TN SHIP, 502 Deaderick Street, 9th Floor, Nashville, TN 37243;
Fax: (615) 741-3309; Email: tn.ship@tn.gov
Got Questions? Please call our hotline at 877-801-0044.**

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: _____

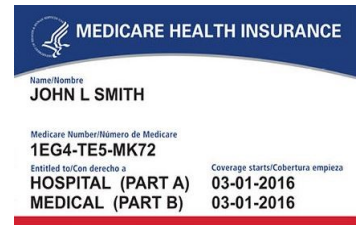
If you would like a personalized search and already have a Medicare.gov account, please provide your account information below.

Username : _____

Password: _____

If you do not have a Medicare.gov account, or are not sure, please provide your Medicare information below so that we can look you up. An account can be created for you if you like. We will provide you with this information.

Medicare Number: (full number required)	
Part A Start Date:	
Part B Start Date:	



Do you have any of the following coverages?

Medicaid/TENNCARE?	YES	NO	Retiree Insurance?	YES	NO
TRICARE or VA?	YES	NO	Federal Employee Health?	YES	NO

Do you currently have Part D Drug Coverage? YES NO **Is this an advantage plan?** YES NO
If so, what is the name of your current plan? *You should be able to get this from your drug or advantage plan card.*

Are you interested in changing the type of plan that you are on? YES NO
(moving from Original Medicare to an Advantage plan or moving from Advantage to Original Medicare)

How would you like to get your comparison? _____
(postal mail, email, phone call)

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Does any of the following apply to you?

The state pays my Part B premium.

YES NO

I already qualify for and receive Extra Help with my prescription costs.

YES NO

I would like help applying for assistance programs to help with the costs of Medicare.

YES NO

If you agree that you would like help applying for assistance, a TN SHIP staff member or volunteer will reach out to you to start the screening process. There are several programs available if you qualify.

Is your household's total gross income below \$1,615 if single, \$2,174 if married?

Total income from all sources? _____

What is your total assets and resources? _____

(Do not include your residence or vehicle)

Do you currently take prescription medications? If so, please list in the chart below. Add a page if more space is needed.

YES NO

What is your preferred pharmacy and location _____

Would you be interested in information about pharmacies that may be cheaper?

YES NO

Do you get your medications through mail order?

YES NO

Name of Medication	Generic ok? Y/N	Strength/Dosage	Frequency	How often do you refill this medication?
<i>Example: Lipitor</i>	<i>no</i>	<i>Example: 20 mg</i>	<i>Example: 30 or one per day</i>	<i>Example: 90 day supply</i>

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Counselor Name _____ Date of Comparison ____/____/____

Changed/enrolled in a different plan? YES NO Name of plan? _____

Part D Outcomes: Original plan cost? _____ New Plan cost? _____ Savings? _____

Comparison and Enrollment Confirmation uploaded to STARS? YES NO