Medicare Prescription Drug Plan Worksheet

Before comparing Medicare drug plans, fill out this worksheet front and back to help you find the plan that best meets your needs. Gather all your prescription drug bottles, your red, white and blue Medicare card and any other health insurance cards to help you complete this worksheet.

1. What is your name as it appears on your Medicare Card?

   _____

2. What is your Medicare Claim Number?

   _____

3. What is the effective date for your Medicare?

   Part A _____ / _____ / _____

   Part B _____ / _____ / _____

What is your date of birth? _____ / _____ / _____

Do you receive:

Social Security 'Extra Help' to pay for your drug plan?

☐ yes ☐ no

Help to pay for Part B premiums?

☐ yes ☐ no

Do you have any of the following:

☐ VA; ☐ Federal Retiree Health Benefits;
☐ TRICARE Insurance; ☐ Union Coverage;
☐ Former Employer Retiree Health Insurance;
☐ Supplemental/Medigap/Plan 65

What county do you live in?_____

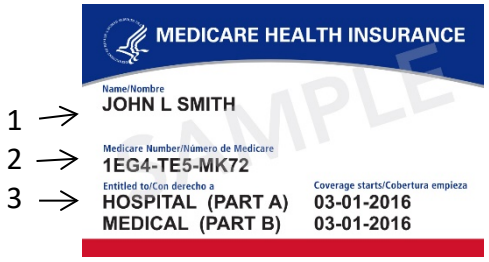
Address _____

City, State Zip _____

Phone Number _____

Email Address _____

Is there a pharmacy you prefer to use? _____



Please Enter Prescription Drugs on Back

For SHICK Counselor Use:

Date: _____

Counselor: _____

MyMedicare UserID: _____

Password: _____

Enrolled: ☐ yes ☐ no

Deduct from Social Security?

☐ yes ☐ no

Compare Last Year? _____

Current Plan: _____

Current Plan OOP: _____

New Plan: _____

New Plan OOP: _____

Savings: _____

Time: _____

Understand Using Plan ☐ yes ☐ no

Understand Estimated Annual Cost

☐ yes ☐ no

Date Reported to SHIP: _____

Notes:

Which drugs do you currently take? (Please also list the dosage and how often you take it per month.) PLEASE PRINT CLEARLY-

Drug Name	Dosage (#mg/pill)	Frequency 30-Day Quantity (1 pill/day would be 30)

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