MEDICARE DRUG PLAN REVIEW FORM

All information is kept in the strictest confidence!

Name: _____Ms./Mrs./Mr._____
Last (Sr./Jr) First M/I

Phone(____)_____ Cell:(____)_____ E-Mail_____

Address:_____
Street City Zip County

Contact Person_____E-Mail_____

Phone(____)_____ Cell:(____)_____

IMPORTANT: If you provide **complete and accurate information**, we can provide more **complete and accurate estimates** for you.

MEDICARE HEALTH INSURANCE

1-800-MEDICARE (1-800-633-4227)

Name_____

Medicare Claim Number: _____

Hospital (Part A) Effective Date: _____

Medical (Part B) Effective Date: _____

Date of Birth: _____

Married ___ **Single** ___

This information will help us to provide you with options that could help reduce your drug costs. **Please note**: If you are not interested in Extra Help with expenses do not complete the income section. We will still provide drug plan information without the financial information.

****Income:** Please list the total monthly **GROSS** amount (**before deductions**) of any income you plan to receive in the next year. If you are married and living together, please list incomes for both yourself and your spouse.

Source	You	Spouse
Social Security	$	$
Retirement Income: (Annuity, IRA, Pension, 401(K) etc.)		
Wages Gross: before deductions		
Net Rental Property income		
Other Interest Income:		
Any other income: Source:		

****Assets:** Please list the approximate value of any liquid assets**:**

Bank accounts (savings and checking) $_____ CD's $_____ IRA's $_____

Stocks $_____ Bonds $_____Annuity $_____

The value of real estate other than your primary residence $_____

Cash value of extra vehicles $_____

The information you are being asked to provide is needed to determine if you are eligible to receive Older American Act Services and to comply with federal reporting requirements. The information requested will allows us to obtain the most accurate information about your drug coverage options. This information will be stored in a secure electronic database and will not be used for any other purpose. Your information will not be shared with another agency without your permission. This information will not be sold to anyone. You have the right review your record and request changes to assure accuracy. You will not be denied most services if you refuse to provide this information. If you have questions, please discuss with the counselor.

Do you have SeniorCare ___YES; ___NO - Level:____ Do you receive extra help? No or YES_____%

VA Drug coverage ___YES; ___NO. Current Drug Plan:_____ Premium $_____

Current Health Plan: _____ Premium $_____

Preferred Pharmacy(1): _____ Preferred Pharmacy(2):_____

Pharmacy Zip Code: _____ Date of Birth:_____ Age___

Your Zip Code:_____ Your County:_____

Would you consider alternative pharmacies for cost savings? ___YES; ___NO
Would you consider mail order for cost savings? ___YES; ___NO
Would you consider generic alternatives in order to reduce your drug costs? ___YES; ___NO

Medication: *that you purchase from the pharmacy*	**Dosage** (mg, mcg)	How Many Times per Day?	Total Number of Pills, Tubes, Pens, Vials **per Month**
(Attach added a separate page of additional prescriptions)			

If you know your Plan Finder Drug ID_____ Password Date:___/____/____

OFFICE USE ONLY. Counselor Notes:☐Compare to SC; ☐Find PAP; ☐Coupon; ☐Milwaukee

:_____

_____

RUN: ☐General Search; ☐Current Plan; ☐PDP; ☐MAPD

PRINT: ☐Drug List; ☐Side by Side; ☐Pharm Costs

VOLUNTEER: _____
DATE _____/____/_____
Return to: RE, JH, GW _____ OR ☐Mail

Return completed form to: 1402 Pankratz St., Suite 111 Madison, WI 53704