CAC Community Action Committee OFFICE ON AGING

TN SHIP Medicare Information & Counseling 1-877-801-0044

Date: _____

Medicare Part D Prescription Plan Worksheet

I prefer to receive my comparison by: ☐ *MAIL* ☐ *PHONE* ☐ *EMAIL*

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 return to: AMOS Program, Knoxville-Knox County CAC Office On Aging.
Mail: PO Box 51650, Knoxville TN 37950-1650 Email: amos@knoxseniors.org
Got Questions? Please call the Office on Aging at 865-524-2786 or the TN SHIP 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: _____

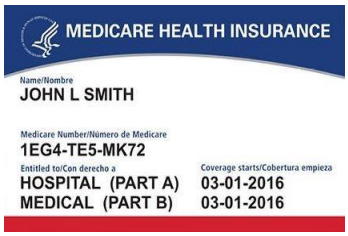
If you would like a personalized search and already have a Medicare.gov account, please provide your account information below. If you would rather not include this account information or your Medicare number on this form, but would still like a personalized search, an Office on Aging specialist can call you once the document is received to gather this info.

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 account information.*

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

TN SHIP Form Modified by Knoxville-Knox County OOA. TN SHIP is supported in part by a grant from the US Administration for Community Living, Department of Health and Human Services. AMOS is supported by Federal/State. Knox County, and Foundations/Grants

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**

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, an Office on Aging 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 $1,903 if single, $2,575 if married?

Total income from all sources? _____

What are your total assets and resources? _____

(Do not include your one residence or one 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 prefer mail order Prescriptions?

YES NO

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

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