

Medicare Health and Rx Plans Worksheet

*** PLEASE PRINT INFO NEATLY FROM YOUR MEDICARE CARD - FILL IN THE BLANKS ***

The image shows a simulated Medicare Health Insurance card. At the top left is the Medicare logo. The title "MEDICARE HEALTH INSURANCE" is in large white letters on a blue background. Below the title, there are several fields for information: "Name/Nombre" with a blank line; "Medicare Number/Número de Medicare" with a blank line; "Entitled to/Con derecho a" with "HOSPITAL (PART A)" and "MEDICAL (PART B)" listed below it; and "Coverage starts/Cobertura empieza" with two blank lines. A red bar is at the bottom of the card.

The above "card" must be filled out with all the information that appears on your actual card, or we're not able to help you.

Today's Date: _____ Name: _____ Date of Birth: _____

Address: _____ City: _____ Zip: _____

County: _____ Phone #: (_____) _____

Email Address : _____

You must complete this worksheet in order for us to help you look at your options. One form per person.

Circle the correct answer and fill in the blanks if it applies to you:

Do you currently have prescription drug coverage? Yes No Plan: _____

Do you get help paying your prescription plan's premium? Yes No Not Sure

Do you have insurance besides Medicare which pays your medical bills? Yes No
What is it? _____

What type of insurance do you want us to look at?

- Original Medicare with a medi-gap (supplemental) and Rx plan
- Medical and Prescription together, i.e. Advantage plans: HMO, PPO
- Both - I'm not sure which is best for me.

Pharmacy Preference: _____ **(Turn Over)**

Income and Assets: (To determine eligibility for *Extra Help* from Social Security)

INCOME if single: Below \$2,015 monthly? _____ ASSETS: Below \$18,090? _____

INCOME if married: Below \$2,725 monthly? _____ ASSETS: Below \$36,100? _____

Please fill out your prescription information below as accurately as possible from the information on your bottles/boxes.

<u>Drug Name</u> (list only the prescription medicines)	<u>Dosage (mg)</u>	<u># of pills/bottles/inhalers used per month</u>
<u>PILL SAMPLE:</u> Coumadin(Warfarin Sodium)	20 mg	30
<u>INSULIN SAMPLE:</u> Novolin 70/30	20 units daily	3 bottles
<u>DROP OR INHALER SAMPLE:</u> Xalatan eye drops	.005%	1 bottle
<input type="checkbox"/> GENERIC OK		
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Return this form to Evergreen:

**Evergreen Commons
Attn: Resource Office
480 State St.
Holland, MI 49423**

A SHIP counselor will complete your search of plans and contact you to schedule an appointment to explain your options. You will choose the plan that seems best for you. We do not sell any plans.

MEDICARE.GOV USERNAME & PASSWORD:

Username: _____

Password: _____