

Medicare Part D Rx Plan Finder worksheet

A free, unbiased service of the Washington State Office of the Insurance Commissioner, the Statewide Health Insurance Benefits Advisors (SHIBA) provides consumers with information about their Medicare Part D prescription drug options.

The following worksheet provides us with the necessary information we need to create a report for you. Once you complete the worksheet, please take it to a SHIBA Medicare Part D counseling clinic in your local county, or mail it to:

SHIBA King County
Statewide Health Insurance
Benefits Advisors
2208 2nd Ave., Ste. 100
Seattle, WA 98121

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 Medicare.)

City: _____ State: _____ Zip: _____

Phone: () _____ County: _____ Email: _____

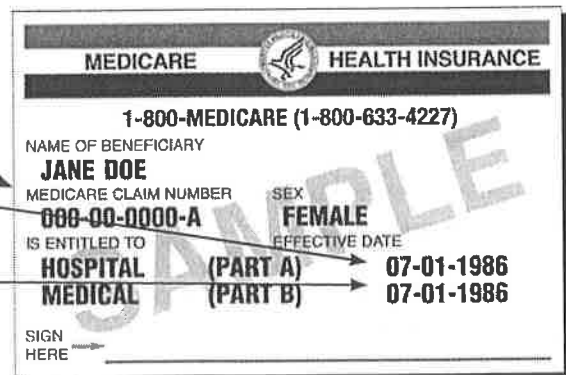
Do you live in Washington state year round?

Yes No

What is YOUR Medicare claim number?

What is YOUR effective date for Part A?

What is YOUR effective date for Part B?



Do you currently have insurance coverage for prescriptions? Check all that apply:

- Federal
- State of WA employee health plan
- Employer's health plan
- Retiree coverage
- Dept. of Veterans Affairs
- Other (please name): _____
- TRICARE for Life

Please send my prescription drug report to the following address:

Name: _____

Mailing address: _____

Check if you're interested in either of following Medicare prescription drug coverage plans:

Medicare Stand-Alone Prescription plans

Medicare Advantage (MA) plans (Part C)

NOTE: If you're interested in an MA plan, include the current name(s) of your doctor(s) and/or clinic(s):

If you have limited income, "Extra Help" is available with prescription drug benefit costs (approximate monthly income less than \$1,500/single person and \$2,200/couple). It could save you a lot of money each year on your prescription drugs. Would you like more information about this? Yes No

Please provide us with information about your prescriptions and pharmacy. NOTE: Your pharmacy might print you a **COMPUTERIZED LISTING TO ATTACH**. If you're unable to provide a computerized list, please print clearly using the table below:

Name of drug	Strength	Daily dosage
<i>Example: Lipitor</i>	<i>Example: 10 mg</i>	<i>Example: Twice daily</i>

I prefer to have my prescriptions filled at this pharmacy(s): _____

Please check all that apply:

- I'm willing to use a different pharmacy.
- I prefer to use a mail-order pharmacy.
- I live in a long-term care facility.

FOR OFFICE USE ONLY

Drug List Password ID# _____

Password Date _____ Zip code _____

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