Medicare Plan Finder Worksheet

For office use only
Zip code:
Drug ID:
Password:

Purpose of this worksheet:
This worksheet will help you gather the information you need to make health care coverage decisions for **2018** during this Medicare Open Enrollment Period, ***during October 15th through December 7th for effective coverage January 1st, 2018.*** Our agencies below can also help create a report for you based on information provided on the official U.S government website, Medicare.gov.

Once you complete the worksheet, please send it to one of the following agencies and we will call you to make an appointment over the phone or in person to discuss your plan results. Services are free, unbiased, and confidential. Either agency below will provide you a comparison of your three most affordable plan options.

Whatcom Alliance for Health Advancement (WAHA) **Whatcom SHIBA Program** 800 E Chestnut St. LL Ste. 2 Bellingham, WA 98225 **Local:** 360-788-6533 **Fax:**360-788-6587 **Email:** waha@hinet.org *WAHA mission is to connect people to health care resources. Our SHIBA program is a service of the Washington Office of the Insurance Commissioner, hosted locally by the Whatcom Alliance for Health Advancement (WAHA). Assists all ages on Medicare over the phone or by appointment.*	**Aging and Disability Resources/NWRC** 600 Lakeway Dr., Suite 100 Bellingham, WA 98225 **Local:** 360-738-2500 *A service of the Northwest Regional Council (NWRC). Assists and provides wide array of services targeted for seniors and people with disabilities.*

Other ways to review your coverage on your own:

1. **INTERNET,** go to www.medicare.gov and in the Health and Drug Plans section click on “Compare Drug and Health Plans.” Use the worksheet to enter your personal information and find the most affordable plan that meets your needs.

OR…

2. **TELEPHONE,** call 1-800-MEDICARE (633-4227). A representative will ask you for the information on this worksheet, and will assist you in finding a plan.

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Personal Information

Name: _____ **Date of Birth:**_____

(*Please provide your name as it appears on your Medicare card)*

Address:_____

(*Please provide the mailing address and ZIP code you have on file with Social Security Administration)*

City:_____**State:**_____**ZIP:**_____

Phone:(_____)_____**Email:**_____

Language spoken at home: _____ **Do you live in WA all year around?** Yes or No

Is someone assisting you to fill out this worksheet? ☐Yes ☐No

Name of person assisting:_____

Phone :(_____)_____Relationship:_____

Address:_____ City: _____

State:_____ZIP:_____ Email: _____

Do you want your report sent to the family member/caregiver/etc. listed above?
☐Yes ☐No

What is your Medicare Claim Number?

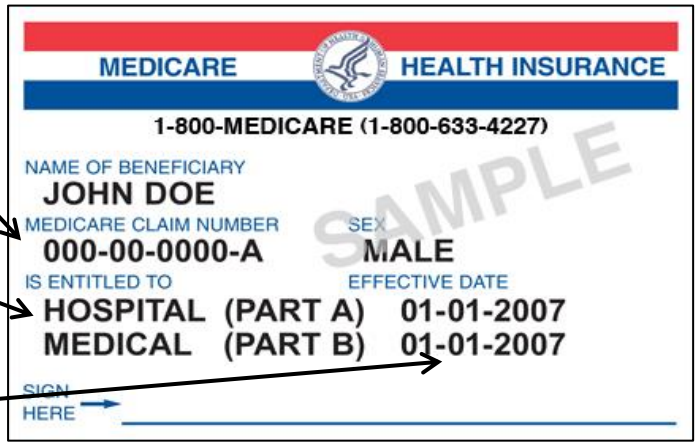
_____

What is your Part A Effective Date?

_____

What is your Part B Effective Date?

_____



Briefly describe what sort of Medicare plan information you would like us to provide you with:

Example: I want help choosing a Medicare Advantage plan for next year.

_____

_____

Continues on the next page →

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

☐ Medicare Stand-Alone Prescription drug plans
☐ Medicare Advantage (MA) plans that include drug coverage

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

_____

_____

Do you <u>currently</u> have insurance coverage for prescriptions? ☐Yes ☐No

If you checked "YES", check all that apply below:

☐ Medicare Prescription Drug Plan (Part D) Plan name: _____
☐ Medicare Advantage Plan (Part C) Plan name:_____
☐ Federal Employees Health Benefit Plan Plan name: _____
☐ Tricare for Life/Veteran's Administration Plan name: _____
☐ State of WA Employee Health Plan Plan name: _____
☐ Retiree Coverage or Employer Based Plan Plan name: _____
☐ Enrolled Tribal Member/Indian Health Services Plan name_____
☐ Marketplace plan on WAhealthplanfinder Plan name: _____

Information about Assistance with Medicare Costs

Did you apply for and receive approval from Social Security to pay for your Medicare Part D prescription premium and deductible? ☐Yes ☐No ☐I'm not sure

Does DSHS help to pay for your Medicare Part B premium?
☐Yes ☐No ☐I'm not sure

Have you been issued a ProviderOne Card, like the one on the right, by DSHS?
☐Yes ☐No ☐I'm not sure

If yes, please provide your client ID #

_____

Information about Assistance with Medicare Costs

There are Medicare assistance programs available to help with medical and prescription drug costs. What is your household's monthly gross income (before taxes/deductions are taken out)?
$_____ single $_____ couple/married $_____ (3+ people in household)

Would you like more information about this? ☐Yes ☐No

Please provide us with information about your current prescriptions. Note: If you are able to obtain a computerized listing of the drugs you currently taking, please attach that listing to this worksheet. If you need more space, please attach an additional piece of paper.

NAME OF DRUG	STRENGTH	DAILY DOSAGE
Example: Lipitor	*Example: 10mg tablet*	*Example: Twice Daily*

Pharmacy Information
I prefer to have my prescriptions filled at this pharmacy(s):_____
Please check all that apply:
☐I'm unwilling to use a different pharmacy than the one listed above
☐I live in a long-term care facility ☐I prefer to use a mail-order pharmacy