SHINE USE: Date Received Date Returned
--



YOUR MEDICARE PLAN COMPARISON PLEASE FOLLOW ALL INSTRUCTIONS • PRINT CLEARLY



Name		Date of Birth		Age
Address				
(Street)	(Town)	(State)		
Day time Phone #				
	(Only include	e email address if you	want result	ts via email)
If you have a www modicare gov	, account provide le	a in information	horo (DD	INIT CI ENDI VI.
If you have a www.medicare.gov	-	=	_	
<u>Be sure you can log in w</u>	vitnout 2-juctor auth	entication bejor	<u>e providir</u>	<u>ıg n.</u>
USER NAME	PASSWORD			
INFORMATION ON YOUR RED. M.	ULTE O DI LIE MAEDIO	ADE CADO: /District	ll. A	
INFORMATION ON YOUR RED, W		-	cieariy)	
Medicare Number:				
Date Next to: HOSPITAL (Part A) _	ME	DICAL (Part B)		
Name of pharmacy you currently	IICA			
Would you consider changing pha				Voc. No.
would you consider changing prid	irrilacies ii you coulu	save on costs:		Yes No
Are you a Veteran? Yes No	Do vou have Veter	ran Health Care k	enefits?	Yes No
Are you enrolled in MassHealth o	-			
If so, provide your MassHealth ID	=			·
ii so, provide your massification ion	mom your cara.			
Your current insurance coverage	information (check a	ind complete wh	at is appl	icable):
Medigap Plan (Supplement)/In				
Part D Drug Plan Name				
	OR			·
Medicare Advantage Plan (Par	_			
Wedicare Advantage Flair (Far	C C // F latt Natifie			
If your current coverage is a r	etiree plan including Sto	ate, Federal, GIC or	private em	ployer,
check your pl	an's rules <u>before</u> enrollii	ng in a different pla	n.	
ODTIONAL: Vou may be aligible fo	er hanafit programs t	aat can baln with	vour boo	Ith care costs
OPTIONAL: You may be eligible fo		•	-	ith care costs.
If you provide information below,	we will review for be	enerit eligibility*:		
Your (and spouse if applicable) to	tal monthly gross inc	ome from all sou	rces	
(Income <u>before</u> Part B premium is				
(meome <u>before</u> rare b premiani is	deducted from 50cm	ar occurry benefit	ι).	
Your monthly income: \$	Spouse mont	hly income: \$	N	N/A
*Assets may also be a factor of eligibilit				•
income listed, we will inform you of the		_		

<u>Using examples below</u>, print clearly or attach a printed list. (Your pharmacist will print if you need assistance).

Specify if brand name is mandated, otherwise, generic is assumed.

*** DO NOT INCLUDE MEDICATIONS/SUPPLEMENTS OR VITAMINS PURCHASED OVER THE COUNTER ***

DRUG NAME As written on the pkg	DRUG FORM Ex: Tablet, Capsule, Syringe, Ointment	DRUG STRENGTH	DOSAGE	HOW OFTEN FILLED AT PHARMACY Do not write "As needed"	For Non-Pills PACKAGE SIZE
Example: Atorvastatin	Tablet	10mg	1/day	every 90 days	
Example: Enbrel – Brand only	Prefilled syringe	50 mg	1/week	monthly	4-pack
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					
17.					
18.					
19.					
20.					

Mail this completed form to: AgeSpan ATTN: SHINE 280 Merrimack Street, Suite 400 Lawrence, MA 01843

This area for SHINE office use:	
Notes	