SHINE USE: Date Received_____Date Returned_____

YOUR MEDICARE PLAN COMPARISON

PLEASE PRINT CLEARLY

Name_____Date of Birth ___ |___ |___ Age ____

Address_____ Zip Code_____

(Street) (Town) (State)

Day time Phone #_____Email Address_____

(Only include email address if you want results via email)

If you have a www.medicare.gov account, provide log-in information here:

USER NAME _____**PASSWORD**_____

If you do not have an account, we will create one for you and will send the info with your plan comparison report.

INFORMATION ON YOUR RED, WHITE & BLUE MEDICARE CARD: (Print clearly)

Medicare Number_____

Note: If it looks like an O, it is a zero

Coverage Start Date: HOSPITAL (Part A) _____ MEDICAL (Part B) _____

Name of pharmacy you use _____

Would you consider changing pharmacies if you could save on costs? Yes __ No __

Would you consider using a mail order pharmacy, if you could save on costs? Yes __ No __

Are you a Veteran? Yes __ No __

Are you enrolled in MassHealth (Medicaid)? Yes __ No __

Do you receive Extra Help (LIS)? Yes __ No __

Are you enrolled in Prescription Advantage? Yes __ No __ I don't know what that is ___

Your current insurance coverage information (check and complete what is applicable):

__ Medigap Plan/Insurer _____Monthly Premium:_____

__ Part D Drug Plan/Plan Name_____ Monthly Premium:_____

__ Medicare Advantage Plan (Part C)/Plan Name _____

If your current coverage is from a retiree plan, check your plan's rules before enrolling in a different plan.

OPTIONAL: You may be eligible for benefit programs that can help with your health care costs. If you provide information below, we will review for benefit eligibility*:

Your (and spouse if applicable) total **monthly gross** income
(Income before Part B premium is deducted from Social Security benefit):

Your monthly income: $_____ **Spouse monthly income**: $_____ **N/A**_____

*Assets may also be a factor of eligibility. If it appears you may be eligible for benefit programs based on income listed, we will inform you of the asset limits to further determine eligibility.

Provide your list of medications on the other side of this form →

Using examples below, print clearly or attach a printed list. (Your pharmacist will print if you need assistance).
If medication MUST be brand only, please notate. 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** **Do not write "As needed"**	***For Non-Pills*** **PACKAGE SIZE**
Ex. *Atorvastatin*	*Tablet*	10mg	*1/day*	*every 90 days*	---
Ex: *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_____
_____
_____
_____
_____