GEORGIACARE$
Local Help for People with Medicare

Medicare Plan Worksheet

www.mygeorgiacares.org

Medicare Part D or Medicare Part C

1-866-552-4464 Option 4

2018 Enrollment

GeorgiaCares would like to help you find affordable prescription plan coverage. The following questionnaire will help GeorgiaCares counselors provide a comparison report of prescription plans that best meet your needs.

Name: _____

Date of Birth: ____/____/_____ (Please provide your name as it appears on your Medicare card)

Address:

_____

(Please provide the address and zip code on file with SSA)

City: _____ State: _____ Zip: _____

County: _____

Phone: ( ) _____

What is your Medicare Claim Number? _____

What is your effective date for Medicare Part A? _____

What is your effective date for Medicare Part B? _____

Medicare Claim Number

Effective Date Part A

Effective Date Part B

Do you currently have insurance coverage for prescriptions? Yes ___ No___

If yes, check any that apply:

____Medicare Part D Plan Name_____
____Medicare Advantage Plane Name_____
____Medicaid
____Employer/ Union Group Health Plan
____Federal Employee Health Benefit Plan
____TRICARE for Life
____Veteran's Administration
____Medigap/ Medicare Supplement
____Other _____
(retirement, private, etc.)

Do you have help paying your prescription co-pays or insurance premiums (Extra Help or Medicare Savings Program)? Yes ___ No___

Would you like a GeorgiaCares counselor to assist you in applying for the Extra Help or a Medicare Savings Program? Yes____ No____

Please check the option you prefer.
I am interested in learning about Medicare prescription drug coverage available through:

_____ **Medicare Stand-alone Prescription Drug Plans (Part D)** – This plan is for beneficiaries that want to stay in the Original Medicare and keep the Medicare Supplement Plan. This plan offers prescription coverage only.

_____ **Medicare Advantage Plans** – This plan offers coverage for hospital, medical care and prescription drugs. You may have provider restrictions.

Deductible (Plans with reduced or $0 deductibles may have a higher annual cost.) Do you prefer plans with?

___$400 deductible
___Reduced to zero deductible
___Doesn't matter

Pharmacy Choice - I prefer to have my prescriptions filled at the pharmacy listed:

_____

Do you prefer mail order? Yes ___ No ___

Please provide information about your prescriptions and pharmacy. You may attach a printout from your pharmacy and any additional information. If you do not have a printout please complete the chart below.

Name of Drug	Strength	Quantity per Month
Example: Lipitor	Example: 20 mg.	Example: 30 or one per day
1.		
2.		
3.		
4.		
5.		
6.		
7		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

Drug ID: _____

Password Date: _____
(Office use only)