



Local Help for People with Medicare **2018 Enrollment**
1-866-55-AGING
1-866-552-4464

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: GA Zip: _____ County: _____

Phone: () _____ Marital Status _____

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?

- \$320 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.		
16.		
17.		
18.		
19.		

Drug ID: _____ Password Date: _____
 (Office use only) (Office use only)

Counselor: _____

Address: