Open Enrollment Period (Oct. 15 – Dec. 7)

Medicare Part D Prescription Drug Plan Finder Tool

855-408-1212 • www.ncshiip.com

The Seniors' Health Insurance Information Program (SHIIP) can help you find a Medicare Prescription Drug Plan to meet your needs and assist you with enrolling in a plan. The following questionnaire provides the information that SHIIP staff and volunteers need to prepare a report for your consideration.

SHIIP
NC DEPARTMENT OF INSURANCE
MIKE CAUSEY, COMMISSIONER

Once completed, **please take this form to a counseling clinic in your county** or mail to:
Margie DiDona or Lisa Alley, Randolph Senior Adults, 347 W. Salisbury Street, Asheboro, NC 27203

Name: _____ **Date of Birth:** _____
(Please provide your name as it appears on your Medicare Card)

Address: _____
(Please provide the address and zip code you have on file with Medicare)

City: _____ **State:** _____ **Zip:** _____

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

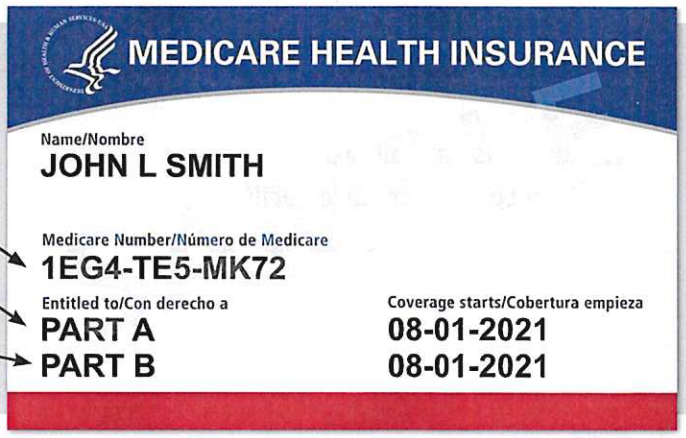
Do you live in NC year round? ☐ Yes ☐ No **What is your primary language (if not English)?** _____

How did you learn about SHIIP? _____

What is YOUR Medicare Number?
_____

What is YOUR effective date for Medicare Part A?
_____

What is YOUR effective date for Medicare Part B?
_____



Do you currently have insurance coverage for prescriptions? ☐ Yes ☐ No

☐ Federal Employees Health Benefit Plan/TRICARE for Life/Veterans' Administration

☐ NC State Employee Health Plan ☐ Retiree Coverage

Please send my report to the family member/caregiver/etc. listed below:

Name: _____ Phone : ( ) _____

Address: _____

Relationship: _____ Email: _____

Are you interested in learning about Medicare prescription drug coverage available through:

☐ Medicare Stand-alone Prescription Drug Plans ☐ Medicare Advantage Plans (Medicare, HMOs, PPOs, PFFS, etc.)

In 2022, do you pay more than $9.85 for brand name drugs and $3.95 for generic drugs? ☐ Yes ☐ No

There are assistance programs available to help with prescription drug benefit costs.

Does your monthly income level fall below **$1,699**/single or **$2,289**/married (living together)? ☐ Yes ☐ No

Do your assets fall below **$14,010**/single or **$27,950**/married (living together)? ☐ Yes ☐ No

Please provide us with information about your prescriptions and pharmacy. NOTE: You may be able to obtain a computerized listing from your pharmacist/pharmacy to attach. If not, please complete the chart below.

NAME OF DRUG	STRENGTH	DAILY DOSAGE	FILL FREQUENCY
Example: Lipitor	*Example: 10 mg.*	*Example: Twice Daily*	*Example: Every 30 days*

I prefer to have my prescriptions filled at this pharmacy(s) _____

Please check all that apply: Doctors:

☐ I would be willing to use a different pharmacy.

☐ I prefer to use a mail order pharmacy.

☐ I live in a Long-Term Care Facility.

NOTES

For office use ONLY

Username _____

Password _____

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This project was supported, in part by grant number 2101NCMISH from the U.S. Administration for Community Living, Department of Health and Human Services, Washington, D.C. 20201. Grantees undertaking projects under government sponsorship are encouraged to express freely their findings and conclusions. Points of view or opinions do not, therefore, necessarily represent official Administration for Community Living policy.