

ANNUAL ELECTION PERIOD OCT. 15 – DEC. 7

Medicare Part D Prescription Drug Plan Finder Tool

1-855-408-1212 • www.ncshiip.com

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



Once completed, please take this form to a counseling clinic in your county or mail to:
North Carolina SHIIP, 1201 Mail Service Center, Raleigh NC 27699-1201

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: _____

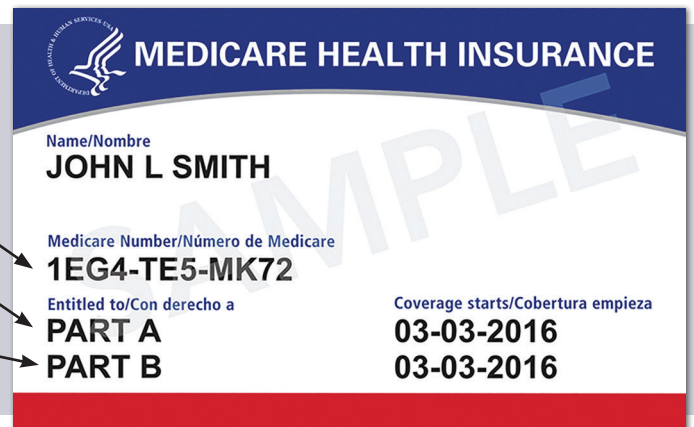
Do you live in NC year round? Yes No What is your primary language (if not English)? _____

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.)

Do you pay more than \$8.25 for brand name drugs and \$3.30 for generic drugs? Yes No

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

Does your monthly income level fall below **\$1,518**/single or **\$2,058**/married? Yes No

Do your assets fall below **\$14,100**/single or over **\$28,150**/married? 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
<i>Example: Lipitor</i>	<i>Example: 10 mg.</i>	<i>Example: Twice Daily</i>

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

Please check all that apply:

- 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.

For office use ONLY

Drug List ID# _____

Password _____

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