Seekonk Human Services Independent Medicare Insurance Counseling Form

Office Use Only:
Received

MEDICARE OPEN ENROLLMENT – October 15th through December 7th

Please read and complete form in its ENTIRETY

!! IMPORTANT !! RETURN form by NOVEMBER 15th to ensure adequate time for review and/or enrollment

THIS BOX FOR OFFICE USE ONLY

Drug Search by: _____ Change in Drug Plan Needed? ☐Yes ☐No If yes, Savings: $

☐ Service Entered in My Senior Center

General Information

Name:			**Date of Birth:**
Address:			**Marital Status:** ☐ **Married** ☐ **Single**
City: Seekonk	**State: MA**	**Zip Code: 02771**	**Phone Number:**
Email:			**Language:** ☐ **English** ☐**Other:**
Emergency Contact:			**Relationship:**
Phone Number:			

Existing Coverage Information

Do you want to compare your Part D Plan? ☐Yes ☐ No	Current Part D Plan:
Do you have a Medicare Advantage Plan? ☐Yes ☐ No If Yes, Plan Name:	Do you have a Supplement/Medigap Plan? ☐Yes ☐No If Yes, Plan Name:
Do you have other health insurance? ☐Yes ☐ No If yes, name of plan:	

Other Important Information

Let's Look at Your Medicare Card **ALWAYS Keep this Information Safe and Secure**	☐ **I have a mymedicare.gov – Here's my account information** ☐ I Do NOT have an account. I need instructions to create one **Always KEEP a record of your MyMedicare.gov information**
Medicare Number:	**Username:**
Part A Effective Date:	**Password:**
Part B Effective Date:	**Security Question:**
	Answer:

Review for Medicare Savings Programs	**Your Pharmacy & Other Rx Information**
☐ **Single**: Monthly **income** is below $2,954 ☐Yes ☐No	Preferred Pharmacy:
☐ **Married:** Monthly **income** is below $3,985 ☐Yes ☐No	Second Pharmacy Choice:
I know I am receiving the following benefits:	Do you want Mail Order Costs provided? ☐Yes ☐No
☐ Medicare Savings Program (Buy-In or Senior Buy-In)	Are there medications not being covered now? ☐Yes ☐No
☐ MassHealth	1)
I receive help paying for my prescriptions: ☐Yes ☐No	2)
I receive help paying for my Part D Premium: ☐Yes ☐No	

!! IMPORTANT !! Please READ and COMPLETE BOTH sides of this form

Please provide us with a list of your PRESCRIPTION MEDICATION - You may be able to get a list from your pharmacy or doctor BUT YOU MUST review it for accuracy.

- **ONLY list medications you are CURRENTLY TAKING and/or medications you WANT included in your drug search**
- **DO NOT list medications you are no longer taking!**
- **DO NOT list over the counter medications – they are NOT covered by your Part D Plan**
- **You MUST indicate how often you fill your prescription - Every 30/60/90 days vs only once or twice a year**
- **DO NOT list that you are taking any medication *"AS NEEDED"* – We need to know approximately how often you fill it (per month or per year) – It WILL impact costs so make your best guess**

Other important information when filling out this form:

- **We will NOT modify medication lists at your appointment so please be sure your list is ACCURATE on this form**
- **Form MUST BE RETURNED before your appointment will be scheduled.**
- **If you use Insulin Pens, indicate the number of PENS you need per month, NOT the units.**
- **If you use eye drops or creams, indicate the size of the bottle or tube AND how many times you fill it per month**

This is my PRESCRIPTION Drug List

Name of Drug	Strength	Dose	How Often Filled-Month/Yearly
Example 1: Novalog (Insulin)	Ex: 70-30 Mix	Ex: 3 times per day	Ex: 10 Pens per month
Example 2: Lipitor	Ex: 10 Mg.	Ex. 1 pill per day	Ex: Every 30 days (Monthly)

Do you have any problems, comments or concerns you would like to discuss at your appointment?

ONCE COMPLETED, PLEASE RETURN THIS FORM BY NOVEMBER 15th TO:

Seekonk Human Services

540 Arcade Avenue, Seekonk, MA 02771

508-336-8772