

# Medicare PlanFinder worksheet

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## Questions to consider during Medicare Open Enrollment

*Note: Medicare Open Enrollment runs October 15 - December 7 for coverage to take effect on January 1.*

- Are you comparing options for the coming year?
- Are you new to Medicare this year?
- Did you recently move to your county?
- Is your plan leaving the area?

## You can get help with your Medicare options three different ways!

You will first need to gather some information and then fill out the worksheet on the following pages to help you with Medicare coverage decisions.

### Option 1: Call your local Statewide Health Insurance Benefits Advisors (SHIBA) program

<Sponsor name> hosts your local SHIBA program whose network of volunteers serves <County name> County residents with their Medicare options. Our volunteers provide one-on-one counseling and will research options and share them with you so you make an informed decision. SHIBA is a free, unbiased and confidential service of the Washington State Office of the Insurance Commissioner.

Call us for in-person and phone appointments; we also have language assistance available.

Placeholder for sponsor label  
with local phone no. and address

### Option 2: You can self-serve by going online

Go to: [www.medicare.gov](http://www.medicare.gov) and click on the green button “Find health & drug plans” under the first row of blue buttons near the top of the page. Use the worksheet to enter your personal information to find the plan that best meets your needs and pocketbook.

### Option 3: Give 1-800-MEDICARE a call

Call 1-800-MEDICARE (800-633-4227) and a Medicare representative will ask you for the information you entered on the worksheet. They’ll use [www.medicare.gov](http://www.medicare.gov) to help offer you options so you can find a plan that fits your needs.

## Medicare PlanFinder Worksheet - Page 2

**Note:** If you plan to move, please note the ZIP code you anticipate moving to.

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

(Please provide your name as it appears on your Medicare card)

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_

(Please provide the mailing address and ZIP code you have on file with Social Security Administration)

**State:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_ **Phone:** (\_\_\_\_) \_\_\_\_\_

**Need an interpreter? Circle one:** Spanish Russian Chinese Korean Vietnamese Other? \_\_\_\_\_

**Authorized Representative Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

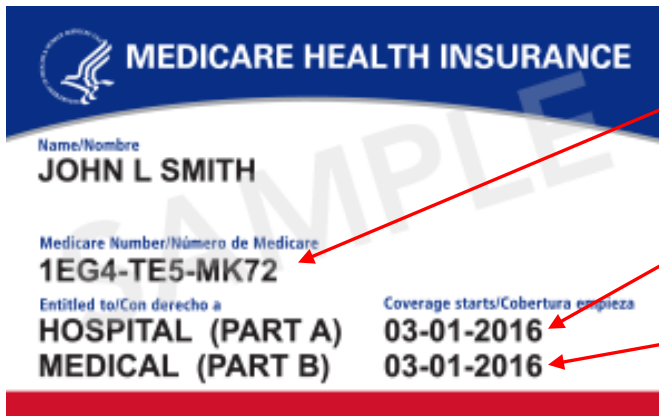
**Relationship to you:** \_\_\_\_\_ **Auth. rep. email:** \_\_\_\_\_

(The person you designate to advocate, assist or handle affairs related to your health care services.)

**Can we contact and share info with your auth. rep.?**  YES  NO

**How do you want us to follow up with you?**  Phone  Email  Both Phone & Email

**Your email address:** \_\_\_\_\_



**What is your Medicare Number?**

\_\_\_\_\_

**What is your Part A start date?**

\_\_\_\_\_

**What is your Part B start date?**

\_\_\_\_\_

**Briefly describe what sort of Medicare plan information you would like us to provide you with, such as "I want help choosing a Medicare Advantage plan for next year."**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**After we research your options, do you want us to contact you for a phone or in-person appointment?**  Yes  No

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# Medicare PlanFinder Worksheet - Page 3

To narrow down your options...

List clinics & providers you go to:

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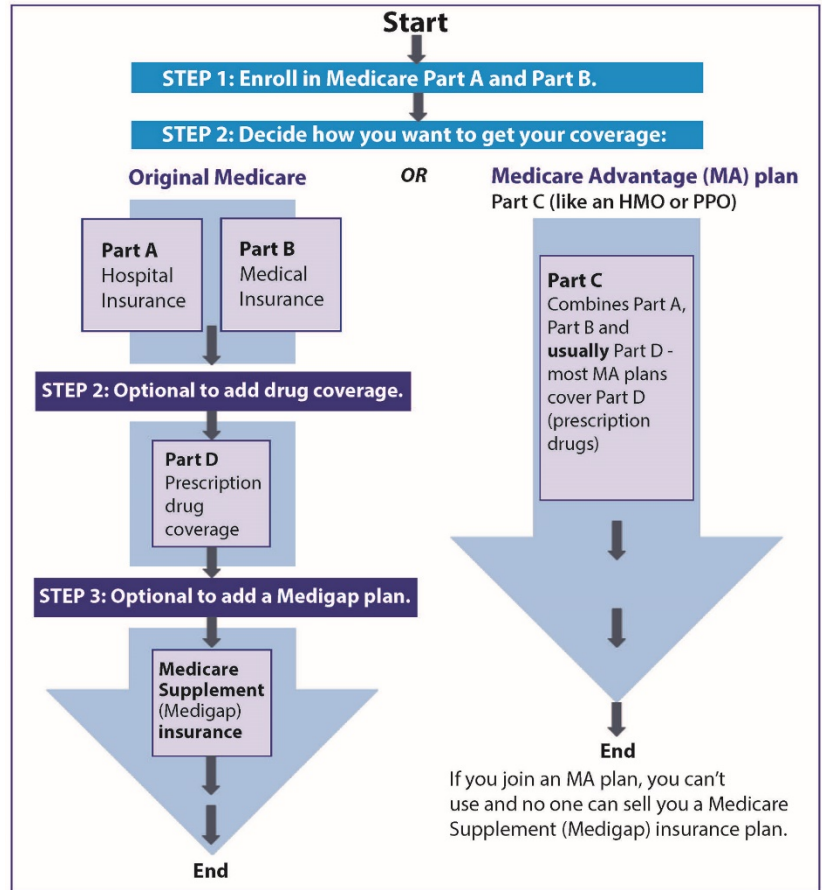


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I currently have the following coverage ... (Check all that apply)

- Original Medicare Parts A and B
  - Medicare Part D plan – Company name: \_\_\_\_\_
  - Medicare Supplement plan – Co. name: \_\_\_\_\_
  - Medicare Advantage plan – Co. name: \_\_\_\_\_
  - Apple Health Medicaid
  - Employer-sponsored health insurance from my own job/spouse's job
  - Tricare for Life/CHAMPVA
  - Veterans Administration
  - Indian Health Services
  - Federal Employee Health Plan
  - Public Employee Benefits Board plan
  - Other retiree coverage – plan name: \_\_\_\_\_
- 
- WAHealthplanfinder Marketplace plan:
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## Your Medicare coverage choices



## Current Medicare assistance

Do you get help paying for your Medicare Part B premium?

- Yes  No  I'm not sure

Do you have a ProviderOne card like the one shown below?

- Yes  No  I'm not sure



If yes, please provide your client ID #:

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## Medicare PlanFinder Worksheet - Page 4

### Get help with Medicare costs

We help screen and apply for Medicare assistance programs on your behalf to see if you qualify for help to pay for your medical and prescription drug costs. What is your household's monthly gross income (before taxes/deductions are taken out)?

\$ \_\_\_\_\_ single \$ \_\_\_\_\_ couple/married \$ \_\_\_\_\_ (3+ people in household)

Would you like us to help you apply for these programs?  Yes  No

**Please provide us with a list of your current prescriptions.** If you can get a computerized list of the drugs you currently take, please attach a copy of it to this worksheet. Otherwise, if you need more space below, attach an additional piece of paper.

DRUG NAME	STRENGTH	DAILY DOSAGE
<i>Example: Metformin</i>	<i>Example: 30mg tablet</i>	<i>Example: Take it twice daily</i>
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

### Pharmacy information

I prefer to have my prescriptions filled at these pharmacies: \_\_\_\_\_

#### Please check all that apply:

I'm unwilling to use a different pharmacy than the one listed above

I prefer to use a mail-order pharmacy

I live in a long-term care facility/Name of facility: \_\_\_\_\_

**For office use only:** Date Plan finder Worksheet was received: \_\_\_\_\_ Received by (fax/email/mail)? \_\_\_\_\_

Medicare.gov details: Zip code: \_\_\_\_\_ Drug ID: \_\_\_\_\_ Password Date: \_\_\_\_\_

Follow up call/email: Attempt 1 (date): \_\_\_\_\_ Attempt 2 (date): \_\_\_\_\_ BCF#: \_\_\_\_\_

Time duration to process PlanFinder: \_\_\_\_\_ (minutes)

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