Medicare PlanFinder worksheet

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.

Option 2: You can self-serve by going online
Go to: 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 to help offer you options so you can find a plan that fits your needs.
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

Continues on the next page →
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: ________________________

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 #: ________________________

Continue on the next page →
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.

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

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) Created 8-7-2019