OFFICE of the INSURANCE COMMISSIONER
SHIBA WASHINGTON STATE

Medicare PlanFinder worksheet

NOTE: Medicare Open Enrollment occurs October 15 - December 7 for coverage to take effect on January 1.

Call your local Statewide Health Insurance Benefits Advisors (SHIBA) program

Our volunteers provide one-on-one counseling and will research options and share them with you so you can make an informed decision. **SHIBA is a free, unbiased and confidential service of the Washington State Office of the Insurance Commissioner**.

Call us for appointments: By phone, email, through an online meeting platform, such as Zoom, or in-person (limitations apply). We also have language assistance available.

Placeholder for local
Phone no.

If you want SHIBA help, please mail, email or fax this completed worksheet to:

Placeholder for local mailing address,
fax number and e-mail address if used

Plan ahead! Don't wait until the last minute to make your choices. Medicare's annual Open Enrollment Period ends December 7. Some people have different deadlines. If you're not sure, please ask SHIBA.

Complete one form per person. PLEASE PRINT CLEARLY.

Name: _____
(*Provide your name as it appears on your Medicare card)*

Date of birth: _____/_____/_____
Month Day Year

Address: _____ **City:** _____
(*Provide the mailing address and ZIPcode you have on file with Social Security Administration)*

State: _____ **ZIP:** _____ **Phone:** (_____)_____

Need an interpreter?
❑ Spanish ❑ Russian ❑ Chinese ❑ Korean ❑ Vietnamese ❑ Other: _____

Authorized representative name:_____
(The person you designate to advocate, assist or handle affairs related to your health care services.)

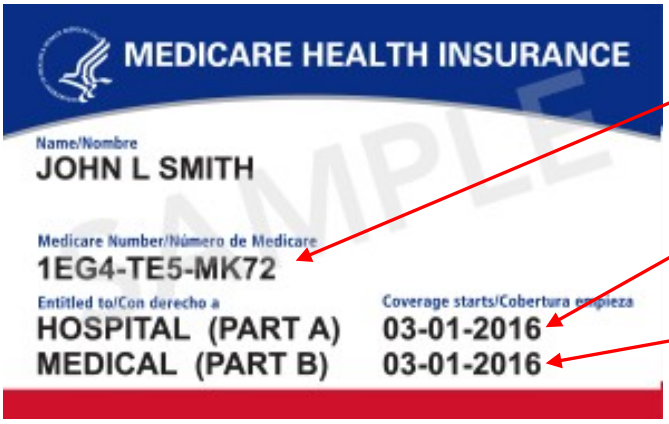
Relationship to you: _____

Auth. rep. phone: (____)_____ **Auth. rep. email**:_____

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

How do you want us to follow up with you? ❑ 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," or "I am comparing my drug plan choices only." List clinics & providers you prefer.

_____
_____
_____
_____

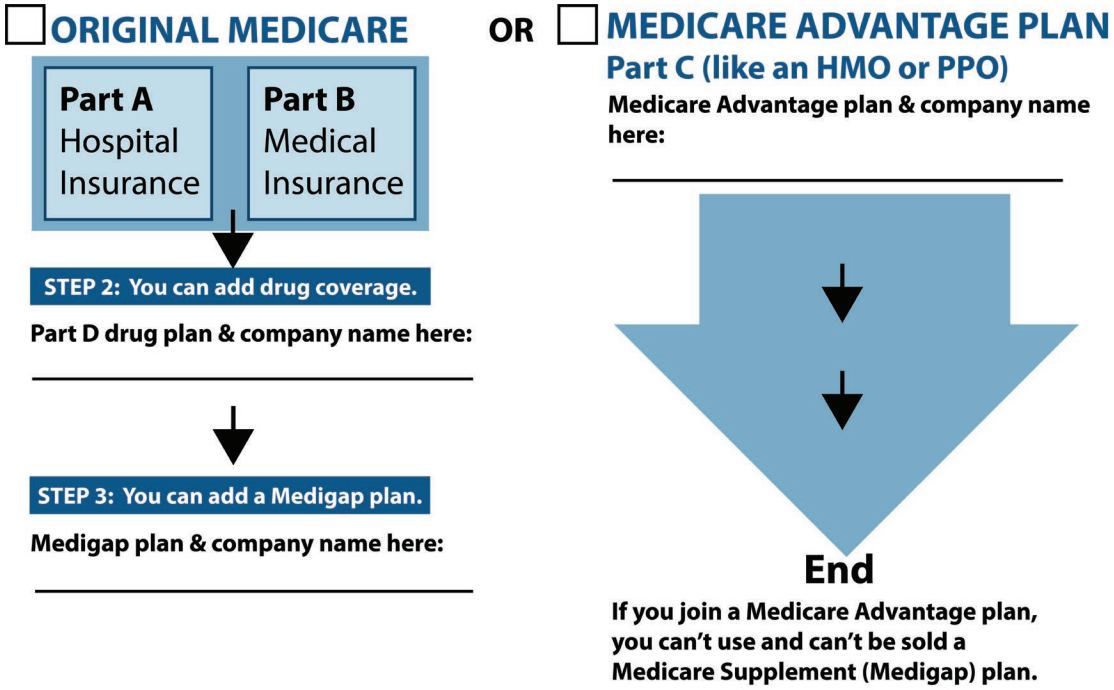
Name: _____

If you have a MyMedicare.gov account it is OPTIONAL to complete this section: Your MyMedicare.gov account allows you to securely store your drug list and more quickly compare plans.We will only use this information to do a Part D or Medicare Advantage comparison for you.

Username: _____ Password: _____

Your current coverage

There are two ways to get your Medicare: Original Medicare or Medicare Advantage plans. Please check a box for which way you get your Medicare. Next, please get out your insurance cards and write down the company and plan name in the appropriate place. If you are not sure, leave this area blank.



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 to the right here?

❑Yes ❑No ❑I'm not sure

Get help with Medicare costs

We help people apply for Medicare assistance programs that could help pay for medical and prescription drug costs. Would you like more information about how to qualify?

❑ Yes ❑ No

Name: _____

Your prescription drugs

Please provide us with a list of your current prescriptions. If you can get a printed list of the drugs you currently take, attach a copy of it to this worksheet. If you need more space, attach an additional piece of paper. **One form per person**. ***PLEASE PRINT CLEARLY.***

DRUG NAME	STRENGTH	DAILY DOSAGE
Example: Metformin	*Example: 30mg tablet*	*Example: Two times daily*
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

Pharmacy information

I prefer to have my prescriptions filled at these pharmacies: _____

_____

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 PlanFinder worksheet was received: _____Received by (fax/email/mail)? _____***
Medicare.gov details: Zip code:_____ User Name:_____ Password:_____
Follow up call/email: Attempt 1 (date):_____ Attempt 2 (date):_____BCF#:_____
Time duration to process PlanFinder:_____(minutes) ***Rev. 8/4/2020***