OFFICE of the INSURANCE COMMISSIONER WASHINGTON STATE
SHIBA

SAMPLE 1

Medicare Part D Rx Plan Finder worksheet

A free, unbiased service of the Washington State Office of the Insurance Commissioner, the Statewide Health Insurance Benefits Advisors (SHIBA) provides consumers with information about their Medicare Part D prescription drug options.

The following worksheet provides us with the necessary information we need to create a report for you. Once you complete the worksheet, please take it to a SHIBA Medicare Part D counseling clinic in your local county, or mail it to:

ENTER YOUR SHIBA SPONSOR
MAILING INFO LABEL HERE

Name: Dick Tracy 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: Your Town State: ____________ Zip: Your Zip

Phone: ( ) ____________ County: ____________ Email: ____________

Do you live in Washington state year round?

☐ Yes ☐ No

What is YOUR Medicare claim number?

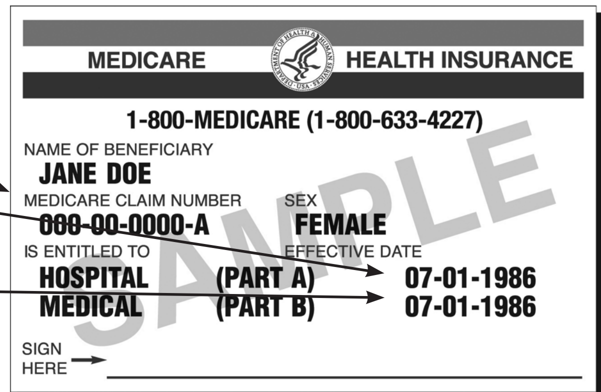
____

What is YOUR effective date for Part A?

____

What is YOUR effective date for Part B?

____



Do you currently have insurance coverage for prescriptions? Check all that apply:

☐ Federal
☐ Employer's health plan
☐ Dept. of Veterans Affairs
☐ TRICARE for Life
☐ State of WA employee health plan
☐ Retiree coverage
☐ Other (please name): ____________

Please send my prescription drug report to the following address:

Name: ______________________________

Mailing address: ______________________________

____

Check if you're interested in either of following Medicare prescription drug coverage plans:

☒ Medicare Stand-Alone Prescription plans

☐ Medicare Advantage (MA) plans (Part C)
NOTE: If you're interested in an MA plan, include the current name(s) of your doctor(s) and/or clinic(s):

____

____

If you have limited income, "Extra Help" is available with prescription drug benefit costs (approximate monthly income less than $1,500/single person and $2,200/couple). It could save you a lot of money each year on your prescription drugs. Would you like more information about this? ☐ Yes ☒ No

I already have Extra Help because I have an MSP

Please provide us with information about your prescriptions and pharmacy. NOTE: Your pharmacy might print you a ***COMPUTERIZED LISTING TO ATTACH***. If you're unable to provide a computerized list, please print clearly using the table below:

Name of drug	**Strength**	**Daily dosage**
Example: Lipitor	*Example: 10 mg*	*Example: Twice daily*
Crestor TAB	20 mg	1 x day
Fluoxetine HCI CAP	20 mg	1 x day
Metformin Hel TAB	500 mg ER	4 x day
Aspirin	81 mg	1 x day

I prefer to have my prescriptions filled at this pharmacy(s): Don't care

____

Please check all that apply:

☒ I'm 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 Password ID# ______________________________

Password Date ____________________ **Zip code** ____________________

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OFFICE of the INSURANCE COMMISSIONER
SHIBA
WASHINGTON STATE

SAMPLE 2

Medicare Part D Rx Plan Finder worksheet

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ENTER YOUR SHIBA SPONSOR MAILING INFO LABEL HERE

Name: Betty Boop Date of Birth: 67 years old
(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: Your Town State: ______ Zip: Your Zip

Phone: ( ) ______ County: ______ Email: ______

Do you live in Washington state year round?

☒ Yes ☐ No

What is YOUR Medicare claim number?

______

What is YOUR effective date for Part A?

______

What is YOUR effective date for Part B?

______

MEDICARE HEALTH INSURANCE
1-800-MEDICARE (1-800-633-4227)
NAME OF BENEFICIARY
JANE DOE
MEDICARE CLAIM NUMBER SEX
000-00-0000-A FEMALE
IS ENTITLED TO EFFECTIVE DATE
HOSPITAL (PART A) 07-01-1986
MEDICAL (PART B) 07-01-1986
SIGN HERE →
SAMPLE

Do you currently have insurance coverage for prescriptions? Check all that apply: No

- ☐ Federal
- ☐ Employer's health plan
- ☐ Dept. of Veterans Affairs
- ☐ TRICARE for Life
- ☐ State of WA employee health plan
- ☐ Retiree coverage
- ☐ Other (please name): ______

Please send my prescription drug report to the following address:

Name: ______________________________

Mailing address: ______________________________

____

Check if you're interested in either of following Medicare prescription drug coverage plans:

- [X] Medicare Stand-Alone Prescription plans
- [ ] Medicare Advantage (MA) plans (Part C)

NOTE: If you're interested in an MA plan, include the current name(s) of your doctor(s) and/or clinic(s):

____

____

If you have limited income, "Extra Help" is available with prescription drug benefit costs (approximate monthly income less than $1,500/single person and $2,200/couple). It could save you a lot of money each year on your prescription drugs. Would you like more information about this? [ ] Yes [X] No

Please provide us with information about your prescriptions and pharmacy. NOTE: Your pharmacy might print you a ***COMPUTERIZED LISTING TO ATTACH***. If you're unable to provide a computerized list, please print clearly using the table below:

Name of drug	**Strength**	**Daily dosage**
Example: Lipitor	*Example: 10 mg*	*Example: Twice daily*
Crestor TAB	20 mg	1 x day
Fluoxetine HCI CAP	20 mg	1 x day
Metformin HCL TAB	500 mg ER	4 x day
Aspirin	81 mg	1 x day

I prefer to have my prescriptions filled at this pharmacy(s): Don't care

____

Please check all that apply:

- [X] I'm willing to use a different pharmacy.
- [X] I prefer to use a mail-order pharmacy.
- [ ] I live in a long-term care facility.

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Drug List Password ID# ______________________________

Password Date ____________________ **Zip code** ____________________

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OFFICE of the INSURANCE COMMISSIONER WASHINGTON STATE
SHIBA

SAMPLE 3

Medicare Part D Rx Plan Finder worksheet

A free, unbiased service of the Washington State Office of the Insurance Commissioner, the Statewide Health Insurance Benefits Advisors (SHIBA) provides consumers with information about their Medicare Part D prescription drug options.

The following worksheet provides us with the necessary information we need to create a report for you. Once you complete the worksheet, please take it to a SHIBA Medicare Part D counseling clinic in your local county, or mail it to:

ENTER YOUR SHIBA SPONSOR MAILING INFO LABEL HERE

New to Medicare
Part A & B start November 1, 2017

Name: George Jungle 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: Your Town State: ____________ Zip: Your Zip

Phone: (   ) ____________ County: ____________ Email: ____________

Do you live in Washington state year round?

☐ Yes ☐ No

What is YOUR Medicare claim number?

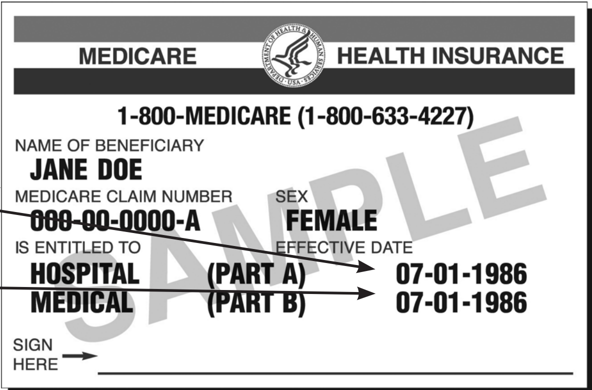
____

What is YOUR effective date for Part A?

____

What is YOUR effective date for Part B?

____



Do you currently have insurance coverage for prescriptions? Check all that apply: No

☐ Federal
☐ Employer's health plan
☐ Dept. of Veterans Affairs
☐ TRICARE for Life
☐ State of WA employee health plan
☐ Retiree coverage
☐ Other (please name): ____________

Please send my prescription drug report to the following address:

Name: ____

Mailing address: ____

____

Check if you're interested in either of following Medicare prescription drug coverage plans:

- [X] Medicare Stand-Alone Prescription plans
- [ ] Medicare Advantage (MA) plans (Part C)

NOTE: If you're interested in an MA plan, include the current name(s) of your doctor(s) and/or clinic(s):

____

____

If you have limited income, "Extra Help" is available with prescription drug benefit costs (approximate monthly income less than $1,500/single person and $2,200/couple). It could save you a lot of money each year on your prescription drugs. Would you like more information about this? ☐ Yes ☒ No

Please provide us with information about your prescriptions and pharmacy. NOTE: Your pharmacy might print you a ***COMPUTERIZED LISTING TO ATTACH***. If you're unable to provide a computerized list, please print clearly using the table below:

Name of drug	**Strength**	**Daily dosage**
Example: Lipitor	*Example: 10 mg*	*Example: Twice daily*
Levothyroxine Sodium Tab	88 mcg	1 x day
Pantoprazole Sodium Tab	40 mg	1 x day
Metoprolol Tartrate Tab	25 mg	2 x day
Pradaxa CAP	150 mg	2 x day

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

____

Please check all that apply:

- [ ] I'm willing to use a different pharmacy.
- [ ] I prefer to use a mail-order pharmacy.
- [ ] I live in a long-term care facility.

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Drug List Password ID# ____

Password Date ____________________ **Zip code** ____________________

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OFFICE of the INSURANCE COMMISSIONER
WASHINGTON STATE
SHIBA

SAMPLE 4

Medicare Part D Rx Plan Finder worksheet

A free, unbiased service of the Washington State Office of the Insurance Commissioner, the Statewide Health Insurance Benefits Advisors (SHIBA) provides consumers with information about their Medicare Part D prescription drug options.

The following worksheet provides us with the necessary information we need to create a report for you. Once you complete the worksheet, please take it to a SHIBA Medicare Part D counseling clinic in your local county, or mail it to:

Practice PF for Medicare
Advantage plans (if applicable)

ENTER YOUR SHIBA SPONSOR
MAILING INFO LABEL HERE

Name: Marge Simpson 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: Your Town State: ______ Zip: Your Zip

Phone: ( ) ______ County: ______ Email: ______

Do you live in Washington state year round?

☐ Yes ☐ No

What is YOUR Medicare claim number?

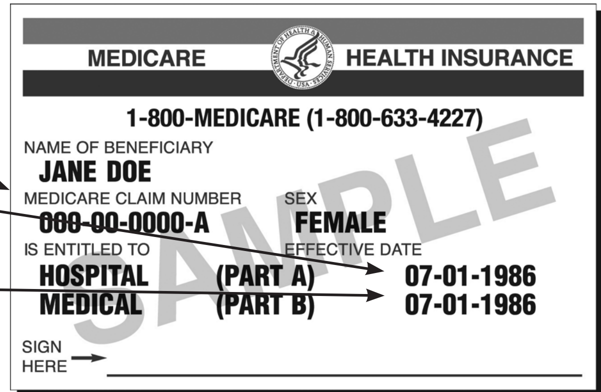
______

What is YOUR effective date for Part A?

______

What is YOUR effective date for Part B?

______



Do you currently have insurance coverage for prescriptions? Check all that apply: No

☐ Federal
☐ Employer's health plan
☐ Dept. of Veterans Affairs
☐ TRICARE for Life
☐ State of WA employee health plan
☐ Retiree coverage
☐ Other (please name): ______

Please send my prescription drug report to the following address:

Name: ______________________________

Mailing address: ______________________________

____

Check if you're interested in either of following Medicare prescription drug coverage plans:

☐ Medicare Stand-Alone Prescription plans

→ ☒ Medicare Advantage (MA) plans (Part C)

NOTE: If you're interested in an MA plan, include the current name(s) of your doctor(s) and/or clinic(s):

____

____

If you have limited income, "Extra Help" is available with prescription drug benefit costs (approximate monthly income less than $1,500/single person and $2,200/couple). It could save you a lot of money each year on your prescription drugs. Would you like more information about this? ☐ Yes ☒ No (Not eligible)

Please provide us with information about your prescriptions and pharmacy. NOTE: Your pharmacy might print you a ***COMPUTERIZED LISTING TO ATTACH***. If you're unable to provide a computerized list, please print clearly using the table below:

Name of drug	**Strength**	**Daily dosage**
Example: Lipitor	*Example: 10 mg*	*Example: Twice daily*
Furosemide TAB	20 mg	1 x
Losartan Potassium	50 mg	1 x
Warfarin Sodium Tab	7.5 mg	1 x
Atenolol Tab	50 mg	1 x

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

____

Please check all that apply:

☐ I'm willing to use a different pharmacy.

☐ I prefer to use a mail-order pharmacy.

☐ I live in a long-term care facility.

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Drug List Password ID# ______________________________

Password Date ______________ **Zip code** ______________

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