

# 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: \_\_\_\_\_ 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: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ County: \_\_\_\_\_ Email: \_\_\_\_\_

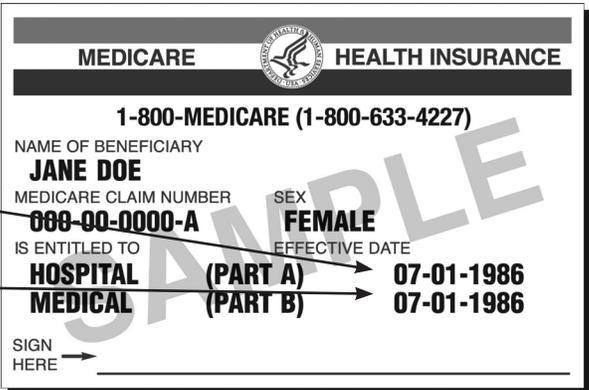
Do you live in Washington state year round?

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

Please send my prescription drug report to the following address:

Name: \_\_\_\_\_

Mailing address: \_\_\_\_\_  
\_\_\_\_\_

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

- Medicare Stand-Alone Prescription plans
- Medicare Advantage plans (Part C)

If you have limited income, "Extra Help" is available with prescription drug benefit costs (approximate monthly income less than \$1,460/single person and \$1,950/couple). It could save you up to \$4,000 per year. 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
<i>Example: Lipitor</i>	<i>Example: 10 mg</i>	<i>Example: Twice daily</i>

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.

**FOR OFFICE USE ONLY**

Drug List Password ID# \_\_\_\_\_

Password Date \_\_\_\_\_ Zip code \_\_\_\_\_

**Phone: 1-800-562-6900 ♦ Email: shiba@oic.wa.gov**



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