

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: (Please provide	Dick Tracy your name as it app	ears on your Medicare	Date of Birth: e card.)	
Address: (Please provide		code you have on file	with Medicare.)	
City:	Your Town	State:	Zip: _	Your Zip
			Email:	
Do you live in W	/ashington state yea	r round?		
☐ Yes	□ No			
What is YC	OUR effective date for	or Part A?	1-800-MEDICARE NAME OF BENEFICIARY JANE DOE MEDICARE CLAIM NUMBER 008-00-0000-A IS ENTITLED TO	SIF
What is YO	OUR effective date for	or Part B?	HOSPITAL (PART A (PART B)	07-01-1986
Do you currentl	y have insurance cov	verage for prescription	ns? Check all that apply:	
☐ Federal		☐ State of WA e	mployee health plan	
_	er's health plan Veterans Affairs	☐ Retiree covera☐ Other (please	nge name):	

Please send my prescription drug report to the follow		
Name:		
Mailing address:		
Check if you're interested in either of following Medic	care prescription drug covera	ge plans:
☑ Medicare Stand-Alone Prescription plans		
Medicare Advantage (MA) plans (Part C) NOTE: If you're interested in an MA plan, incl	ude the current name(s) of y	our doctor(s) and/or clinic(s):
If you have limited income, "Extra Help" is available wincome less than \$1,500/single person and \$2,200/co prescription drugs. Would you like more information a Please provide us with information about your prescription at COMPUTERIZED LISTING TO ATTACH. If you're using the table below:	uple). It could save you a lot about this?	of money each year on your No ecause I have an MSP* Your pharmacy might print
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 pharma	cy(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 OFF	ICE USE ONLY	
Drug List Password ID#		
Password Date	Zip code	



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ENTER YOUR SHIBA SPONSOR MAILING INFO LABEL HERE

Name:	Betty Boop		Date of Birth:	67 years o	old
(Please provide)	your name as it appears on	your Medicare ca	ard.)		
Address: (Please provide t	the address and zip code you	u have on file wit	h Medicare.)		
City:	Your Town	_ State:		Zip: Your	Zip
Phone: ()	County:		Email:		
	ashington state year round?				
X Yes	□ No				
What is YO	UR Medicare claim numbe	r?	MEDICARE	HEALTH	
What is YO	UR effective date for Part A	15	NAME OF BENEFICIARY JANE DOE MEDICARE CLAIM NUMBER 000-00-0000-A	FEMALE	E
What is YO	UR effective date for Part E	3?——		ART A) 07-	01-1986 01-1986
Do you currently	have insurance coverage fo	or prescriptions?	Check all that appl	y: No	
_	r's health plan	Retiree coverage	loyee health plan		

Please send my prescription drug report to the follow	ving address:	
Name:		
Mailing address:		
Check if you're interested in either of following Medi	care prescription drug covera	ge plans:
Medicare Stand-Alone Prescription plans		
Medicare Advantage (MA) plans (Part C) NOTE: If you're interested in an MA plan, inc	lude the current name(s) of yo	our doctor(s) and/or clinic(s)
If you have limited income, "Extra Help" is available wincome less than \$1,500/single person and \$2,200/coprescription drugs. Would you like more information Please provide us with information about your prescription at COMPUTERIZED LISTING TO ATTACH. If you're using the table below:	ouple). It could save you a lot about this?	of money each year on your No Your pharmacy might print
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 pharma	cy(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 OFF	FICE USE ONLY	
Drug List Password ID#		
Password Date	Zip code	



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New to Medicare November 1, 2017 LABEL HERE

Name: (Please provi	George Jungle de your name as it appears o	n your Medicare ca		
Address: (Please provi	de the address and zip code y	ou have on file with	h Medicare.)	
City:	Your Town	State:	Zip: _	Your Zip
Phone: (County	/ :	Email:	
Do you live in	n Washington state year roun	d?		
What is	YOUR Medicare claim numb	er?	1-800-MEDICARE	HEALTH INSURANCE (1-800-633-4227)
What is	YOUR effective date for Part	t A?	NAME OF BENEFICIARY JANE DOE MEDICARE CLAIM NUMBER SE 008-00-0000-A	EEMALE
What is	S YOUR effective date for Part	B?——	IS ENTITLED TO HOSPITAL MEDICAL SIGN HERE	
Do you curre	ntly have insurance coverage	for prescriptions?	Check all that apply:	No
☐ Dept	oyer's health plan	State of WA empl Retiree coverage Other (please nar	oyee health plan me):	

Please send my prescription drug report to the follow	ving address:	
Name:		
Mailing address:		
Check if you're interested in either of following Medi	care prescription drug covera	ge plans:
X Medicare Stand-Alone Prescription plans		
Medicare Advantage (MA) plans (Part C)NOTE: If you're interested in an MA plan, inc	lude the current name(s) of y	our doctor(s) and/or clinic(s):
If you have limited income, "Extra Help" is available vincome less than \$1,500/single person and \$2,200/concepte prescription drugs. Would you like more information Please provide us with information about your prescription at COMPUTERIZED LISTING TO ATTACH. If you're	ouple). It could save you a lot about this?	of money each year on your No Your pharmacy might print
using the table below:		
Name of drug	Strength	Daily dosage
Example: Lipitor Levothyroxine Sodium Tab	Example: 10 mg 88 mcg	Example: Twice daily 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
Traduxa CAT	150 1116	2 X ddy
I prefer to have my prescriptions filled at this pharma	cy(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 OFF	FICE USE ONLY	
Drug List Password ID#		
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Practice PF for Medicare OUR SHIBA SPONSOR Advantage plans (if applicable) FO LABEL HERE

Nam	e: Marge Simpson	1		
(Plea	se provide your name as it appears	on your Medicare	e card.)	
	ess: se provide the address and zip code	you have on file v	with Medicare.)	
City:	Your Town	State:	Zip: Your Zip	
Phor	e: <u>(</u>) Cour	nty:	Email:	
Do y	ou live in Washington state year rou	ınd?		
	☐ Yes ☐ No			
	What is YOUR Medicare claim nun What is YOUR effective date for Pa What is YOUR effective date for Pa	art A?	MEDICARE 1-800-MEDICARE (1-800-633-4227) NAME OF BENEFICIARY JANE DOE MEDICARE CLAIM NUMBER SEX 008-90-0000-A IS ENTITLED TO HOSPITAL (PART A) 07-01-1986 SIGN HERE	
Do y	ou currently have insurance coverag	ge for prescription	ns? Check all that apply: No	
	Employer's health plan	Retiree covera	mployee health plan age name):	

www.insurance.wa.gov/shiba | 1-800-562-6900 | shiba@oic.wa.gov

Please send my prescription drug report to the follo	owing address:	
Name:		
Mailing address:		
Check if you're interested in either of following Med	dicare prescription drug covera	ge plans:
☐ Medicare Stand-Alone Prescription plans		
Medicare Advantage (MA) plans (Part C) NOTE: If you're interested in an MA plan, ir	nclude the current name(s) of y	our doctor(s) and/or clinic(s):
If you have limited income, "Extra Help" is available income less than \$1,500/single person and \$2,200/prescription drugs. Would you like more information Please provide us with information about your preson a COMPUTERIZED LISTING TO ATTACH . If you're using the table below:	couple). It could save you a lot in about this? Yes	of money each year on your \times No (Not eligible) Your pharmacy might print
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
prefer to have my prescriptions filled at this pharn	nacy(s):	
Please check all that apply:		
\square I'm willing to use a different pharmacy.		
☐ I prefer to use a mail-order pharmacy.		
\square I live in a long-term care facility.		
FOR O	FFICE USE ONLY	
Drug List Password ID#		
Password Date	Zip code	