Information Needed To Find a Health or Drug Plan

PLEASE READ FIRST!

1. Please use a separate form for each person requesting help. *This is important because you will be enrolling in Part D plans as an individual not as a couple, so we will be looking at medication lists for one person at a time.*
2. Please, no over-the-counter medications, vitamins, or supplements. *These are never covered in any of the plans.*
3. Please, no medication lists from your pharmacy, *as information is often missing or unclear.*
4. If your medication comes in a bottle as a drop, please indicate how many weeks before you fill the prescription again. *This information is needed to accurately estimate your drug costs.*
5. Please return completed form to:

ADRC of Ozaukee County — 284-8120 (Local)
121 West Main Street, PO Box 994 — 238-8120 (Metro)
Port Washington, WI 53074 — 268-7726 (Fax)

Name: _____

Date of Birth: _____

Street Address: _____

City, State, and Zip: _____

Phone Number: _____

Medicare Number (include letter at end): _____

Effective Date on Medicare Card: Part A_____ Part B _____

By providing your Medicare information we are able to provide a comparison of your current plan and a suggested plan for next year.

How do you currently get your drug coverage?

- ☐ Currently working and receiving help through Employer or Union Group Coverage
- ☐ Retiree Coverage through previous employment
- ☐ Medicare Advantage Plan
- ☐ Medicaid/Forward Card (also known at T-19)
- ☐ SeniorCare
- ☐ Medicare Part D plan
- ☐ Prescriptions through V.A. or TriCare
- ☐ Other: _____

What is the name of your current Part D or Medicare Advantage Plan? _____

(Please remember to sign the disclaimer at the bottom of page 2)

REMEMBER:

1. **No over-the-counter medications, vitamins or supplements.**
2. **No pharmacy medication lists.**
3. **Indicate number of weeks between refills for medications that come in the form of drops.**

Preferred Pharmacy: _____

Generic Name or Brand Name of Drug	Dosage (ex. mg, ml, GM)	How Many Pills a Day	How Often Filled (30 or 90 days)
EX: **1) lisinopril/hctz 2)timolol maleate ophthalmic SOL 0.5%**	**20/25MG 5mL Bottle**	**1/day 1 drop/day**	**90 days 1 bottle per month**

I have requested the Ozaukee County Elder Benefit Specialist's assistance in searching for a Medicare Part D or Medicare Advantage Plan. I understand the accuracy of the search depends on the information I have provided.

Signature:_____ **Date:** _____