

Medicare Plan Comparison Worksheet

Name: _____ Date of Birth _____
 (Please provide your name as it appears on your Medicare card)

Physical Address: _____

(Provide the address and zip code on file with Social Security)

City: _____ State: _____ Zip code: _____ County: _____

Mailing Address: _____

(Provide the address and zip code on file with Social Security)

City: _____ State: _____ Zip code: _____ County: _____

Home Phone: _____ Cell Phone : _____

Please complete the section below using the information from your Medicare Card.

An example has been provided if you are unsure of what your Medicare card looks like. ➡



Medicare Claim Number _____

Part A Coverage Start Date: _____

Part B Coverage Start Date: _____

Income/Subsidy Information

Are you receiving assistance through a Medicare Savings Program (MSP)?

___ Yes ___ No ___ Unsure ___ I would like to be screened

Monthly Gross Income

Applicant: \$ _____ Spouse :\$ _____

What Insurance coverage do you currently have? Please check all that apply

- ___ I am new to Medicare
- ___ Part A (Hospital Only)
- ___ Part A (Hospital) and Part B (Medical)
- ___ Part D (Prescription) Plan Name _____
- ___ Supplemental/Medigap Plan Name _____
- ___ Part C (Medicare Advantage Plan) Plan Name _____
- ___ Medicaid (Ex: Viva, Health Springs, BCBS, Humana, United Health, Aetna, Devoted)
- ___ Other (Employer Coverage, Retiree Coverage, PEEHIP, VA Coverage, TRICARE, Marketplace)

I am interested in reviewing:

- ___ New (Part D) Medicare Prescription Drug Plans
- ___ New (Part C) Medicare Advantage Plans that include Prescription Drug Coverage
- ___ Ensure my current plan is the best plan

Do you have any specific questions or concerns about your coverage?



Part C Medicare Advantage Only:

To help us make sure your doctors and other providers are in the plan's network and service area we need the following: Include Dentist/Optometrlist if applicable

Provider's Name	Provider's Specialty

My doctors are associated with the following hospital systems:

- ☐ Ascension St. Vincent's
☐ Baptist Health system (Brookwood, Princeton, Shelby, Jasper)
☐ Grandview Medical
☐ UAB
☐ Other: _____

SHIP Communication Preferences:

- ☐ **Mail** Plan Comparison Results. I will call if I have questions
☐ **Email** Plan Comparison Results. I will call if I have questions

Email address: _____

- ☐ **Call** me with Plan Comparison results

Other Services

- ☐ **Yes**, I am interested in resources or being screened for other services through M4A
☐ **No**, I am NOT interested in resources or being screened for other services through M4A

How did you hear about our services? _____



Protect Yourself During Medicare Open Enrollment

Watch out for people who:

☐ Ask for your Medicare number	☐ Give you materials that look like they are from official government sources
☐ Ask for your bank information	☐ Call, visit, or text without permission
☐ Ask for your Social Security number	☐ Approach you in parking lots or malls
☐ Pressure you with time limits	☐ Threaten that you will lose your Medicare benefits unless you sign up for their plan
☐ Say they represent Medicare	☐ Offer you gifts to enroll in their plan



SMP
Senior Medicare Patrol
Preventing Medicare Fraud



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ForSHIP Use Only

Counselor: _____

Plan Reviewed: _____

Follow-up Date: _____

Notes: _____

