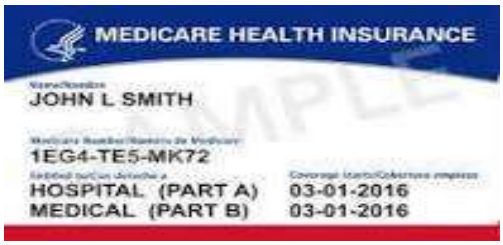
SHIP State Health Insurance Assistance Program | SMP Senior Medicare Patrol | M4A ASSISTING ALL AGES AT ALL STAGES

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_____
(Ex: Viva, Health Springs, BCBS, Humana, United Health, Aetna, Devoted)
___ Medicaid
___ 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/Optometrist 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?_____

For SHIP Use Only

Counselor:_____

Plan Reviewed: _____

Follow-up Date: _____

Notes:_____

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Name:_____ **DOB:**_____ **Pharmacy:**_____

Pharm. Address:_____ **Pharmacy Phone #:**_____

Please list each of your prescriptions in the columns below. Include any form of medication prescribed by a medical doctor including injections, breathing treatments, ointments, creams, etc..

DO NOT INCLUDE OVER THE COUNTER (OTC), MEDICINES, VITAMINS ETC

Medication (ex: Eliquis)	Generic? (Gen)	Name Brand? (NB)	Strength (ex: 5 mg)	Frequency (ex: 2x/day)	Supply Amt (ex: 30 day/60 day/90 day)
	(Gen) ☐	(NB) ☐			
	(Gen) ☐	(NB) ☐			
	(Gen) ☐	(NB) ☐			
	(Gen) ☐	(NB) ☐			
	(Gen) ☐	(NB) ☐			
	(Gen) ☐	(NB) ☐			
	(Gen) ☐	(NB) ☐			
	(Gen) ☐	(NB) ☐			
	(Gen) ☐	(NB) ☐			
	(Gen) ☐	(NB) ☐			
	(Gen) ☐	(NB) ☐			
	(Gen) ☐	(NB) ☐			