North Ottawa County
Council on Aging

Medicare - Part D Worksheet

For Office Use:
Date Received:______________
By:______________

Before filling out this form please have the following items in front of you:

(1) ALL of your prescription medicine bottles
(2) Your Medicare card
(3) Any other Health insurance cards or Prescription Insurance cards

IN ORDER FOR US TO GIVE YOU THE BEST INFORMATION: PLEASE ANSWER ALL OF THE QUESTIONS AND WRITE NEATLY

① **Name:**______________________________ **Phone #:**______________

Address:______________________ **Apt #**______ **City/State/Zip:**______________

County you live in:______________ **Township/City/Village:**______________

Date of Birth:______________ **Age:**__________

② **What type of Insurance do you want us to check out for you?**

- ☐ **Prescription Only**
- ☐ **Prescription with Medical Coverage**
- ☐ **Medical Only**
- ☐ **Medigap (Supplemental Medical Insurance—no copays)**

③ **Look at your Medicare Card** (the one that looks like this one) **and fill in all the blanks**

MEDICARE HEALTH INSURANCE
1-800-MEDICARE (1-800-633-4227)
NAME OF BENEFICIARY
_________ First Name _____ Middle Initial ____________ Last Name
MEDICARE CLAIM NUMBER
_______-_______-_______-_____
IS ENTITLED TO — EFFECTIVE DATE
HOSPITAL (PART A) ____-____-____
MEDICAL (PART B) ____-____-____

④ **If you want medical insurance complete this section** — Put a number (0 to 10) in the blanks to tell us how often you went to the….

- ☐ Dr______________times last year
- ☐ Specialist______________times last year
- ☐ Hospital?______________times last year
- ☐ ER______________times last year
- ☐ Nursing Home__________times last year
- ☐ Lab/blood work?________times last year
- ☐ X-rays?______________times last year

Do you have any upcoming surgeries or Medical needs? Yes No
If yes, what?______________________

⑤ **Circle the Correct answer and fill in the blanks:**

Do you have Prescription Insurance? **Yes** **No**
If "yes" — What is the name of the Insurance:______________________
— What is the monthly premium cost for it:___$______________

Do you have other Medical insurance besides Medicare? **Yes** **No**
If "yes" — What is the name of the Insurance:______________________
— How much does it cost per month?___$______________

For Office Use: Drug List ID #______________________ Date:______________

⑥ Now look at all your Prescription Bottles:

list all of the information on your pill bottle in the below boxes—do this for each medicine that the Dr gives you a prescription for:

Drug Name	Dosage (mg)	# of pills/bottles/inhalers used per month
PILL SAMPLE: ------------Coumadin - Warfarin Sodium --- INSULIN SAMPLE: ---------------- Novolin 70/30 ----------- DROPs: -------------------------- Xalatan eye drops---------- INHALER SAMPLE: ------- ----- Advair Diskus ------------	--------- 20 mg------------ ---------------------------- ----------005%------------ ---------100/50------------	------------------- 30-------------------- ------------------3 bottles------------------ ------------ --------1 bottle---------------- -----------------2 inhalers----------------
☐ GENERIC OK		
☐ GENERIC OK		
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(If all your medications do not fit on this list feel free to attach a list on a piece of paper)

⑦ What Pharmacy do get your medicines at? ______________________ City: ______________

Do you get all of your medicines there? Yes No

If No, where else do you get your medicines? ______________________________

& which medicines do you get there? ______________________________

PLEASE RETURN THIS COMPLETED WORKSHEET TO THE NORTH OTTAWA COUNTY COUNCIL ON AGING. ONCE IT IS RECEIVED WE WILL CONTACT YOU TO SET UP AN APPOINTMENT TO GO OVER YOUR OPTIONS.

Other Ways to look at your options are by:

- calling Medicare at (800) 633-4227 or
- going on the computer to www.medicare.gov or
- by contacting an insurance agent