

Medicare - Part D Worksheet

For Office Use:	
Date Received:	_____
By:	_____

The 2011 Medicare open enrollment period is October 15—December 7. This form must be completed and returned to the North Ottawa County Council on Aging (NOCCOA) prior to setting up an appointment. Please fill in ALL fields on this form and mail, fax, or deliver the completed form to NOCCOA, 422 Fulton Ave., Grand Haven, MI 49417 (fax: 616-842-6110). Submitting an incomplete form will delay your appointment.

To fill out this form you will need: medicine bottles for ALL current prescriptions, your Medicare card, and any other health insurance and/or prescription insurance cards.

1 Name: _____ Phone #: _____

Address: _____ Apt # _____ City/State/Zip: _____

County you live in: _____ Township/City/Village: _____

Date of Birth: _____ Age: _____


2 What type of insurance are you interested in having us research 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

4 Complete this section if you want medical insurance. Fill in the number of times you visited each in the last year.

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)	_____

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, explain: _____

5 Circle the correct answer and fill in the blanks:

Do you have prescription insurance? Yes No

If yes, what is the name of your insurance: _____

What is your current monthly premium: \$ _____

Do you have medical insurance in addition to Medicare? Yes No

If yes, what is the name of your supplemental insurance: _____

What is your current monthly premium: \$ _____

For Office Use: Drug List ID # _____ Date: _____

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List all of the information on your prescription bottles in the boxes below.
Do this for each medicine you have a prescription for.
If you use insulin, inhalers, or drops, list the number of bottles you use each month.

<u>Drug Name</u>	<u>Dosage (mg)</u>	<u># of pills/bottles/inhalers used per month</u>
<u>PILL SAMPLE:</u> -----Coumadin - Warfarin Sodium ---	----- 20 mg-----	----- 30-----
<u>INSULIN SAMPLE:</u> ----- Novolin 70/30 -----	-----	-----3 bottles-----
<u>DROPS:</u> ----- Xalatan eye drops-----	-----005%-----	-----1 bottle-----
<u>INHALER SAMPLE:</u> ----- Advair Diskus -----	-----100/50-----	-----2 inhalers-----
<input type="checkbox"/> GENERIC OK		
<input type="checkbox"/> GENERIC OK		
<input type="checkbox"/> GENERIC OK		
<input type="checkbox"/> GENERIC OK		
<input type="checkbox"/> GENERIC OK		
<input type="checkbox"/> GENERIC OK		
<input type="checkbox"/> GENERIC OK		
<input type="checkbox"/> GENERIC OK		
<input type="checkbox"/> GENERIC OK		
<input type="checkbox"/> GENERIC OK		

(Attach additional sheets if your medications do not fit in the space provided.)

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What pharmacy do you use to fill your prescriptions? _____

City: _____

Do you get all your prescriptions filled there? Yes No

If no, what other pharmacies do you use? _____

Which prescriptions are filled there? _____

You can also research you insurance coverage options:

- by calling Medicare at (800) 633-4227
- by visiting the Medicare website: www.medicare.gov
- by contacting an insurance agent