

# Medicare Plan Comparison Request Form

All information provided is kept confidential

IF YOU HAVE A CARE MANAGER WITH FAMILY CARE THROUGH **COMMUNITY CARE, LAKELAND,** OR **INCLUSA**, PLEASE SEE YOUR FAMILY CARE MANAGER FOR ASSISTANCE WITH YOUR COVERAGE CHOICES. YOU DO NOT NEED TO PROCEED WITH THIS FORM.

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Date of Birth (mm/dd/yyyy): \_\_\_\_\_

Email Address: \_\_\_\_\_

Medicare Claim Number (located on you red, white, & blue card): \_\_\_\_\_

Coverage Start Date: Part A (mm/dd/yy): \_\_\_\_\_ Part B (mm/dd/yy): \_\_\_\_\_

If you **DO** have a **Medicare.gov** account, please provide your information. \*This is not your Social Security Account\*

Username: \_\_\_\_\_

Password: \_\_\_\_\_

I give you permission to securely store my username and password.

Signature: \_\_\_\_\_

If you **DO NOT** have a **Medicare.gov** account, please answer the following questions and sign below so we may create an account for you.

**PLEASE NOTE:** The tool used to compare plans is the *Medicare Health and Drug Plan Finder*, located at [www.medicare.gov](http://www.medicare.gov). Using the information you provide on the next page, the plan finder will sort all available plans and provide important cost estimates and coverage information. While you may not use the account on Medicare's website, allowing us to create an account for you will allow us to do our job more efficiently. Please provide the following information so we may do so.

1. Username (at least 8 characters long): \_\_\_\_\_

2. Password: (at least 8 characters long, and must have letters, numbers, and at least one of these symbols: ! @ \$ \* ( ) ^ : \_\_\_\_\_

3. Choose **ONE** secret question below and provide the answer:

Favorite vacation spot: \_\_\_\_\_

Country you would most like to visit: \_\_\_\_\_

Title of your favorite book: \_\_\_\_\_

City you 1st met your spouse: \_\_\_\_\_

Name of your 1st pet: \_\_\_\_\_

I give you permission to securely store my username and password.

Signature: \_\_\_\_\_

**Please select one of the following:**

- I have an Advantage Plan     I have a Part D Plan     I am unsure

**Please select one of the following:**

**Option #1: In person or phone appointment:** After completed form is received, your appointment will be made. Choose your appointment option below:

- PHONE     IN-PERSON

**Option #2: Pick up your plan options from the ADRC office:** Please call me when my top three plan options are updated and ready to be picked up.

I understand that by selecting this option, I will not be receiving an appointment with a Benefit Specialist at the ADRC of the Lakeshore and will only be receiving a packet with my top plan choices for Open Enrollment.

If you have any questions or concerns, please call the ADRC after receiving your plan options.

**Please initial after reading:** \_\_\_\_\_

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## Medical Information

**Please provide the name of your Primary Care Physician.**

**Name:** \_\_\_\_\_

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**Each plan has their own preferred pharmacy. We encourage listing at least 3 pharmacies that you would be willing to have medications filled at.**

**Pharmacy 1:** \_\_\_\_\_

**Pharmacy 2:** \_\_\_\_\_

**Pharmacy 3:** \_\_\_\_\_

Do you fill prescriptions by mail order? Please choose one.    Yes     No

Would you consider mail order if it were cheaper? Please choose one.    Yes     No

**Please list all current prescribed medications below.** Include any as-needed medications, eye-drops, creams/ointments, etc. **DO NOT** include over-the-counter medications. **Make sure that all medications are current.** Do not attach a list from your doctor, as these lists sometimes contain medications you are no longer taking. **Attach a separate sheet of paper if additional space is needed.**

Current Prescription Name	Dosage and Type of Medication	Quantity	Refill Frequency
Example: Trulicity	1.5 ml/.5ml solution pen injector	3 boxes of 4 pens	Every 2 months

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