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. 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: _____

Medical Information

Please provide the name of your Primary Care Physician.

Name: _____

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 theses lists sometimes contain medications you are no longer taking.** Attach a separate sheet of paper if additional space is needed.

Current Prescription Name Example: Trulicity	Dosage and Type of Medication 1.5 ml/.5ml solution pen injector	Quantity 3 boxes of 4 pens	Refill Frequency Every 2 months
1			
2			
3			
4			
5			
6			
7			
8			
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