Medicare Open Enrollment Form

All information provided is kept confidential

IF YOU HAVE A CARE MANAGER WITH FAMILY CARE THROUGH **COMMUNITY CARE**, **LAKELAND**, **INCLUSA**, OR **MY CHOICE WISCONSIN**, 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 (Required): _____

Medicare Claim Number (located on your red, white, & blue card): _____

Coverage Start Date: Part A (mm/dd/yy): _____ **Part B (mm/dd/yy):** _____

Only fill out 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: _____

Only fill out 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.

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 ONLY 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 note: The tool used to compare plans is the *Medicare Health and Drug Plan Finder*, located at www.medicare.gov. By using the information on this form, the plan finder will sort all available plans and provide cost estimates and coverage information. While *you* may not use a Medicare.gov account, allowing us to create an account for you will allow us to do our job more efficiently and effectively.

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 appointment types:

☐ **Option #1: In person appointment:** After completed form is received, your appointment will be made.

☐ **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.

	Current Prescription Name	Dosage and Type of Medication	Quantity	Refill Frequency
	Look at the prescription container closely and include the entire name listed on the label.	i.e. mg, mcg, ml, etc. i.e. tablet, capsule, vial, tub, jar, pen, ointment, syringe, etc.	How many do you order at a time?	Monthly? Every 2 months? Every 3 months? Etc.
	Example: Trulicity	1.5 ml/.5ml solution pen injector	3 boxes of 4 pens	Every 2 months
	Example: Metformin	2.5 - 250 mg tablets	60	Monthly
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Do you need to list more medications?
Please attach a separate piece of paper.

Internal Use Only

How did client learn about:

- ☐ Previous Contact
- ☐ Presentations
- ☐ Another Agency
- ☐ Media
- ☐ Other: _____
- ☐ Not Collected
- ☐ CMS/Medicare
- ☐ Mailings
- ☐ Friend/Relative
- ☐ State Website

Race/Ethnicity:

- ☐ Hispanic or Latino
- ☐ White, Non-Hispanic
- ☐ Black, African American
- ☐ American Indian/Alaska Native
- ☐ Asian Indian
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Hmong
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Vietnamese
- ☐ Not Collected

Gender:

☐ Female ☐ Male

Marital Status:

☐ D ☐ M ☐ S ☐ W

Living Arrangement:

☐ LA ☐ LO ☐ RC ☐ NH ☐ H ☐ O

Time Spent: _____

_____

_____

Topic: _____

_____

_____

☐ Compared Plans ☐ Enrolled Into New Plan

Notes: _____

_____

_____

_____

_____