

MISSOURI SHIP

State Health Insurance Assistance Program

Medicare Drug Plan Worksheet

OCHC Appointment Information

Location: _____

Address: _____

Date: _____

Time: _____

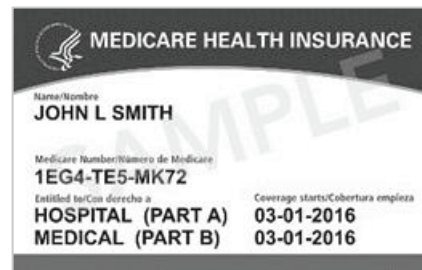
To ensure you have everything you need for a successful counseling session, please complete this form and bring it to your appointment (in person or by phone). Do **NOT** mail it back to us. Also, **be sure to have your Medicare and other insurance cards available, along with your Medicare.gov login credentials** (if you have an account). For a replacement Medicare card, contact Social Security at 1-800-772-1213.

1. Name: _____

2. Phone #: _____

3. Address: _____

4. Zip Code and County: _____



5. What type(s) of prescription drug coverage do you currently have? (Check all that apply)

☐ MO HealthNet (Medicaid)

☐ Medicare Prescription Drug Plan

☐ Medicare Health Plan (i.e., HMO, PPO, PFFS)

☐ Employer or Union Retiree Plan

☐ None of the Above

Medicare #: _____

Effective Date Part A: _____

Effective Date Part B: _____

6. Did you receive a letter from Medicare or Social Security saying you are eligible or qualified for extra help paying for your Medicare Prescription Drug Plan (premium, deductible, and drug costs)?

☐ Yes, I received a letter from Medicare

☐ Yes, I received a letter from Social Security

☐ No, I did not receive a letter

☐ I don't know

(If you received any of the above-mentioned letters, please have it available.)

7. What is your marital status?

☐ Married – Living together

☐ Single

☐ Widowed

☐ Married – Not living together

☐ Divorced

☐ Separated

8. Are your combined savings, investments, and real estate (other than your home) worth MORE THAN:

o **\$18,090** if you are single, a widow(er), or your spouse does not live with you; or

o **\$36,100** if you are married and living together?

Include the things you own by yourself, your spouse, or someone else **EXCLUDING** your home, vehicles, burial plots, or personal possessions.

If the answer to #8 is NO, be sure to ask about the following programs to help save you money:

☐ Extra Help thru Social Security

☐ Medicare Savings Programs (QMB, SLMB, QI-1)

>>> Please complete both sides >>>

9. Pharmacy(s) of choice: _____

Mail order? ☐ Yes ☐ No

Please bring a print-out of your medications, a list of your own, or complete the section below:

Prescription Name	Dosage (e.g. 200mg)	Number of Times Taken Daily

For more information or help, call Missouri SHIP at 1-800-390-3330. We look forward to assisting you at our scheduled appointment.



SHIP
State Health Insurance
Assistance Program



DCI
Missouri Department of Commerce & Insurance

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