

Medicare Part D Worksheet

Persons with Medicare may select a Medicare Part D prescription insurance plan: (1) **when you first enroll in Medicare**, (2) **when you move**, (3) **every year during the Open Enrollment Period**. All insurance plans change every year, so Medicare beneficiaries should compare coverage each year during the Open Enrollment Period, **October 15 – December 7**, of each year.

1. ZIP code _____ Previous ZIP code _____

2. Medicare Claim Number _____

Mr.
Mrs.
Ms.

Last Name First Name M.I. Jr, Sr, II, III

4. Mailing Address _____
Street Address Apartment #

City State

5. Email Address _____

6. Telephone – Preferred _____

Other _____

7. Date Your Medicare Starts (found on Medicare card)

Hospital (Part A) _____ Medical (Part B) _____
mm/dd/yyyy mm/dd/yyyy

8. Date of Birth: _____
mm/dd/yyyy

9. Other person to contact (relative, friend, etc.) Optional

Name: _____

Relationship: _____
(wife, husband, son, daughter, friend, etc.)

Telephone _____ email _____

Address: _____

10. What coverage do you have now? Check all that apply.

Medicare Prescription Drug Plan

Complete Name of Current Plan _____

Medicare Advantage Plan

Complete Name of Current Plan _____

Virginia Medicaid (for those with low incomes & savings)

Retiree or Union Plan that is ending. Date this ends: _____

Current work employee insurance that is ending. Date this ends: _____

None of the above.

11. Do you get financial help (called "Extra Help") with Medicare drug costs?

If you currently get financial "Extra Help", check **Yes** and **Skip** to Question 16.

Yes

No

Don't know

12. To be screened for Extra Help, please answer the questions below and speak with a Medicare Counselor to determine if you may be eligible for financial help. If eligible, a counselor can help you apply.

13. Is your gross income from all sources **GREATER** than:

- **\$1,538/month** if Single, Widow, or Married and living apart, or
- **\$2,078/month** if Married and living together

Yes

No

14. Are your combined savings, investments & real estate **GREATER** than the following?
(Do not include your home, vehicle, personal possessions, or burial expenses.)

\$14,100 if you are Single, Widow, or Married living apart, or
\$28,150 if you are Married and living together.

Yes

No

15. Do you have children or grandchildren living with you in your house? (If yes, you may qualify for financial assistance with a higher income.)

Yes

No

16. Please read directions carefully & Print in the box below.

- Give exact name of drug, including ER, XR, etc. after the name
- If you take generics, give only the generic name.
- List the strength of each drug (for example 100mg, or 0.3% solution)
- List how much do you need for **ONE month** (even if you buy a 90-day supply)
 - **Number** of pills, tablets, capsules you need for **ONE month (30 days)**
 - **Size** of bottles or tubes & **number** you need for **ONE month (30 days)**
 - **Number of boxes of units** (e.g 1 box of 5 insulin pens) for **ONE month**
 - **Number of inhalers (NOT number of puffs per day) for ONE month**

Your analysis will be delayed, if we do not have your complete, correct information.

	<p>Name of Prescription Drug</p> <p>If you take generics, give only the generic name</p>	<p>Strength</p> <p>(example: 500mg for pills, tablets, capsules; or 0.5% for solutions or creams)</p> <p>And the Size</p> <p>(e.g. 2.0 ml bottle, box of 14, or .5 oz tube)</p>	<p>How Much you buy for 1 month (30 days)</p> <p>(for example 30 pills, 1 tube, 1 box of 60 aerosols)</p> <p>Do NOT put "as needed"</p>
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

17. List 2 pharmacies you may use. We suggest you include at least one large, national pharmacy (like Walgreens, CVS or Walmart), as they have lower drug co-pays with some insurance plans and you'll save money.

Pharmacy Name: _____

Pharmacy Name: _____

City: _____

City: _____

18. Do you want prices for Mail Order?

Yes

No

19. **Comments:** (example: My Medicare starts June 1; I moved to Loudoun & need my drug plan to start as soon as possible; I take all generic drugs; please contact my son with analysis results, etc.)

Using the information on this worksheet, you, a friend, or family member can run your analysis on the www.Medicare.gov website. (Please ask our office for step-by-step directions.)

or

If you want the Loudoun County VICAP Medicare Counseling Program to run the analysis for you, return your completed worksheet in one of the ways listed below. We will contact you when your analysis is complete.

• **Mail or Drop Off:**

Loudoun County Dept. of Parks, Recreation, & Community Services -- Area Agency on Aging
c/o VICAP Medicare Counseling Program
742 Miller Drive, SE
PO Box 7800
Leesburg, VA 20177-7800

- **Email** AAAMedicare@Loudoun.gov (or the counselor who sent it to you)
- **FAX** 703-771-5161

