

Medicare Plan Review Information Form

1. What is your name on your Medicare card and address on record with Medicare?

First _____ M.I. _____ Last _____

Address _____

City _____ Zip Code _____ County _____

Phone _____ Email _____

2. What is the best way for us to contact you regarding follow-up questions and/or scheduling?

Phone Email Text message Other _____

3. What is your date of birth (mm/dd/yyyy)? _____

4. What is your current drug coverage? None VA

Medicare Part D Drug Plan: Name of Plan _____

Medicare Advantage Plan: Name of Plan _____

Employer/Retiree Plan _____ Other _____

5. Are you satisfied with your current prescription drug plan and/or Medicare Advantage plan?

Yes No Not sure I don't have one

Please explain: _____

6. Is your income above or below the following amounts?

• Individual: \$19,380/year (\$1,615/month) • Couple: \$26,100/year (\$2,175/month)

Above Below

7. Do you currently receive any of the following benefits?

_____ Medicaid (Title 19 – MEPD, SSI, Elderly Waiver, Medically Needy Spend-down, Nursing Home)

_____ Help paying your Medicare Part B premium (QMB, SLMB, QI)

_____ Extra Help with your Medicare drug costs

8. What pharmacy do you prefer? You may list two:

Name of Pharmacy Address and City Phone Number

Name of Pharmacy Address and City Phone Number

9. Would you consider changing pharmacies if it saves you money? Yes No

Required Information for a Medicare Comparison

The Senior Health Insurance Information Program (SHIIP) is sponsored by the State of Iowa Insurance Division. SHIIP uses the Medicare.gov Medicare Plan Finder to compare Medicare Part D and Medicare Advantage drug plans for individuals. In order for SHIIP to do a comparison for you, you will need to have an online user account with MyMedicare.gov and provide your username and password to SHIIP. An online user account allows you to save your drug list, make updates from year-to-year, and easily compare drug plans. If needed, we can help you create an account to do your comparison(s).

I have a MyMedicare.gov account (complete this section):

Please provide your username and password for your MyMedicare.gov account. We will only use this information to do a Part D or Medicare Advantage comparison for you. Write legibly and be sure to show uppercase and lowercase letters correctly:

Username: _____

Password: _____

I DO NOT have a MyMedicare.gov account and need help creating one

If you don't have a computer or internet access, or if you otherwise need assistance, a SHIIP volunteer will contact you to help set up an account.

How to create your official MyMedicare.gov account:

- Go to <https://www.mymedicare.gov/>
- Click "create an account now" under the *Log in to your account* header
- Complete the fields on this page, entering your:
 - o Medicare number with no spaces or dashes
 - o Last name and suffix (if any), exactly as shown on your Medicare card
 - o Email address (you will need to re-enter it to confirm)
 - o Date of birth
 - o 5-digit zip code
 - o Part A coverage start date from your Medicare card (if you don't have Part A, click the "Switch to Part B" link and enter your Part B coverage start date instead)
- Read and check both boxes at the bottom of the page, then click "Next"
- A security notice will appear on the same page; click "OK" to continue
- You will need to create a username and password following these guidelines:
 - o Username (we suggest using your email address as your username)
 - must be 8-30 characters with no spaces; must include at least 4 letters
 - can include letters, numbers and these special characters: @ ! . - _ \$
 - don't use special character as the first or last character of your username
 - *Examples:* JohnDoe@gmail.com - or - John Doe!1954
 - o Password (you will need to enter and re-enter your password to confirm)
 - must be 8-16 characters; must contain at least one letter and one number
 - must contain one or more of these special characters: @ ! \$ % " * ()
 - cannot contain your username, Medicare number, or Social Security number
 - *Example:* Howdy\$19
- Select a security question from a dropdown list and enter your answer
- Click "Submit," and now you can log in to your account
 - o Medicare will mail you a confirmation letter within 10-14 days

Name: _____

Date: _____

Please list all prescription drugs you are currently taking.

Do not substitute a drug list from your doctor. These can be inaccurate, as they often include short-term prescription drugs from recent hospital stays and over-the-counter drugs.

<p align="center">Prescription Drug List</p> <p align="center">List one drug per row; do not include over-the-counter medicines PLEASE CHECK SPELLING AND PRINT LEGIBLY</p>	<p align="center">Brand or Generic?</p>	<p align="center">Dosage</p> <p align="center">E.g. mg, mcg, %</p>	<p align="center">Frequency</p> <p align="center">E.g. 1 pill/day 1 bottle/month 1 tube/month</p>
<p>Drug Name: _____</p> <p>Circle one: Tablet, Capsule, Caplet, Powder, Patch, Cream, Lotion, Liquid, Syrup, Suspension, Spray, Mist, Drops</p>			
<p>Drug Name: _____</p> <p>Circle one: Tablet, Capsule, Caplet, Powder, Patch, Cream, Lotion, Liquid, Syrup, Suspension, Spray, Mist, Drops</p>			
<p>Drug Name: _____</p> <p>Circle one: Tablet, Capsule, Caplet, Powder, Patch, Cream, Lotion, Liquid, Syrup, Suspension, Spray, Mist, Drops</p>			
<p>Drug Name: _____</p> <p>Circle one: Tablet, Capsule, Caplet, Powder, Patch, Cream, Lotion, Liquid, Syrup, Suspension, Spray, Mist, Drops</p>			
<p>Drug Name: _____</p> <p>Circle one: Tablet, Capsule, Caplet, Powder, Patch, Cream, Lotion, Liquid, Syrup, Suspension, Spray, Mist, Drops</p>			
<p>Drug Name: _____</p> <p>Circle one: Tablet, Capsule, Caplet, Powder, Patch, Cream, Lotion, Liquid, Syrup, Suspension, Spray, Mist, Drops</p>			
<p>Drug Name: _____</p> <p>Circle one: Tablet, Capsule, Caplet, Powder, Patch, Cream, Lotion, Liquid, Syrup, Suspension, Spray, Mist, Drops</p>			
<p>Drug Name: _____</p> <p>Circle one: Tablet, Capsule, Caplet, Powder, Patch, Cream, Lotion, Liquid, Syrup, Suspension, Spray, Mist, Drops</p>			
<p>Drug Name: _____</p> <p>Circle one: Tablet, Capsule, Caplet, Powder, Patch, Cream, Lotion, Liquid, Syrup, Suspension, Spray, Mist, Drops</p>			
<p>Drug Name: _____</p> <p>Circle one: Tablet, Capsule, Caplet, Powder, Patch, Cream, Lotion, Liquid, Syrup, Suspension, Spray, Mist, Drops</p>			
<p>Drug Name: _____</p> <p>Circle one: Tablet, Capsule, Caplet, Powder, Patch, Cream, Lotion, Liquid, Syrup, Suspension, Spray, Mist, Drops</p>			

Prescription Drug List List one drug per row; do not include over-the-counter medicines PLEASE CHECK SPELLING AND PRINT LEGIBLY	Brand or Generic?	Dosage E.g. mg, mcg, %	Frequency E.g. 1 pill/day 1 bottle/month 1 tube/month
Drug Name: _____ Circle one: Tablet, Capsule, Caplet, Powder, Patch, Cream, Lotion, Liquid, Syrup, Suspension, Spray, Mist, Drops			
Drug Name: _____ Circle one: Tablet, Capsule, Caplet, Powder, Patch, Cream, Lotion, Liquid, Syrup, Suspension, Spray, Mist, Drops			
Drug Name: _____ Circle one: Tablet, Capsule, Caplet, Powder, Patch, Cream, Lotion, Liquid, Syrup, Suspension, Spray, Mist, Drops			
Drug Name: _____ Circle one: Tablet, Capsule, Caplet, Powder, Patch, Cream, Lotion, Liquid, Syrup, Suspension, Spray, Mist, Drops			

Inhalers	Dosage E.g. 6.7 gm 8.76 gm	Package size E.g. 1 inhaler, box of # aerosols, blister pack of 14	Frequency E.g. 1 inhaler/month 1 box/month
Drug Name:			

Injections	Pens/Vials # per package	Size E.g. 3 ml vial, 3 ml pen	Amount How many packages, pens, or vials do you use each month?
Drug Name:			

If more space is needed, attach a list of additional drugs, inhalers, and injections. Please include all the details requested above for each drug, including dosage, size, frequency, brand or generic, etc.

SHIP is a free, unbiased counseling program provided by the State of Iowa Insurance Division. This form contains confidential information, and we will not share it with anyone other than your SHIP counselor(s).



Notice to SHIIP—SMP Client



SHIIP—SMP is sponsored by the State of Iowa Insurance Division to make information on Medicare and health insurance more widely available and understandable to Iowans on Medicare and to assist with Medicare fraud and abuse cases. Services are provided by trained volunteer counselors who are not actively affiliated with the insurance, financial planning or pharmaceutical industries.

SHIIP—SMP and its volunteers do:

- Give you helpful information on how you can compare Medicare and health insurance plans.
- Give you information and assistance to make Medicare & health insurance decisions easier.
- Upon request, assist with applications for, and enrollment in Medicare prescription drug plans, health plans and assistance programs.
- Keep all information confidential.
- Assist with Medicare health insurance problems and Medicare fraud & abuse.

SHIIP—SMP and its volunteers do NOT:

- Advise you on the purchase, renewal or termination of specific insurance products.
- Provide legal advice.
- Make decisions for you.
- Endorse or recommend any particular insurance product, agent, company, Medicare Advantage or prescription drug plan.

SHIIP—SMP, its volunteers and sponsors are NOT liable for decisions you make based on information or assistance provided. Health insurance often involves the most important and costly decisions that you can make. You may need to talk to an attorney, accountant, government office, public service agency or other resource before making such a decision.

I understand that my counseling records may be shared between SHIIP—SMP counselors who serve me.

Should you have any complaints or suggestions for making SHIIP—SMP more responsive to your needs, please let us know by calling (800) 351-4664. The Iowa Insurance Division may contact you at a later date to assess your satisfaction with the service provided by the SHIIP—SMP program.

Beneficiary Name (Print)	Beneficiary/Representative Signature	Date
---------------------------------	---	-------------

AUTHORIZATION to RELEASE INFORMATION

I authorize _____ (SHIIP—SMP Counselor) to share with, or collect from, Medicare, Social Security, Iowa Department of Human Services, insurance companies, agents, pharmacies, providers and appropriate enforcement agencies information pertaining to the above named beneficiary’s Medicare and/or health insurance coverage. I understand that the information supplied will be held in trust and used only in ways authorized by the beneficiary or designated representative. This authorization remains valid for 12 months from the date of signature unless earlier revoked in writing.

Beneficiary or Representative Signature	Date
--	-------------