Medicare Plan Finder Questionnaire

Instructions: In order to provide accurate results, it is important that you <u>answer every question</u>

Name: _____ Date of Birth: _____

Address: _____ Zip: _____

Email: _____ Phone: _____

How do you want to receive your results? ☐ Email ☐ Regular Mail

Are you covered by any other insurance for prescriptions? ☐ Yes ☐ No

If you have one of this type of coverage, it is often best to keep it:

TRICARE for Life, VA, Federal, Union, or Employer Group Health Plans
(Contact your benefits administrator before making any changes)

I am interested in reviewing my Part D Drug Plan. ☐ Yes ☐ No

I am interested in reviewing my Medicare Advantage Plan w/ Drug Coverage ☐ Yes ☐ No

My current Part D or Medicare Advantage Plan _____

Medicare Card Information	MyMedicare.gov Account Info
Name:	**Username:**
Number:	**Password:**
Part A effective Date:	**Security Question:**
Part B effective Date:	**Answer:**

Income / Subsidy Information

Does your monthly income fall below $1,630 for Single or $2,198 for Married couple? ☐ Yes ☐ No

Do your Resources/Assets fall below $14,790 for Single or $29,520 for Married couple? ☐ Yes ☐ No

Are you currently receiving? ☐ Extra Help/LIS ☐ QMB ☐ SLMB ☐ QI-1

<u>List 2 Preferred Pharmacies</u>

1. Pharmacy Name & Address: _____

2. Pharmacy Name & Address: _____

Do you want a plan that offers mail order? ☐ Yes ☐ No

Do you spend more than 90 days out of State? ☐ Yes ☐ No

Enter your prescriptions on the reverse side

This project was supported, in part by grant number 90SAPG0083, from the U.S. Administration for Community Living, Department of Health and Human Services, Washington, D.C. 20201. Grantees undertaking projects with government sponsorship are encouraged to express freely their findings and conclusions. Points of view or opinions do not, therefore, necessarily represent official ACL policy.

Medicare Plan Finder Questionnaire – continued

Drug Name Example: (Metformin HCl)	**Strength** (500 mg ER)	**Form of Medication** (tablet, capsule, etc.)	**Daily Dosage** (times per day)

MAXIMUM OF 25 PRESCRIPTION DRUGS – DO NOT LIST *OVER THE COUNTER DRUGS*

Return to: **Pima Council on Aging**
Attention: Medicare Dept.
600 S. Country Club Rd., Tucson, AZ 85716
Phone/Fax: 520-546-2011
Email: ship@pcoa.org

- Results will be limited to **top 3** plans that meet your specific needs and will be sent to you as soon as possible
- PCOA does not recommend nor endorse any Medicare plans or companies and is not responsible for the services provided by these companies.