Open Enrollment Period (Oct. 15 – Dec. 7)

Medicare Part D Prescription Drug Plan Finder Tool

855-408-1212 · www.ncshiip.com

The Seniors' Health Insurance Information Program (SHIIP) can help you find a Medicare Prescription Drug Plan to meet your needs and assist you with enrolling in a plan. The following questionnaire provides the information that SHIIP staff and volunteers need to prepare a report for your consideration.



Once completed, please take this form to a counseling clinic in your county or mail to: Margie DiDona or Lisa Alley, Randolph Senior Adults, 347 W. Salisbury Street, Asheboro, NC 27203

Name:(Please provide your name as it appears on your Medic	Date of Birth:		
Address: (Please provide the address and zip code you have or		, ï	
City:		Zip:	
Phone:	Email:		
Do you live in NC year round? Yes No What is	your primary language (if not	English)?	
How did you learn about SHIIP?	7		
What is YOUR Medicare Number?	MEDICAR	RE HEALTH INSURANCE	
What is YOUR effective date for Medicare Part A?	Name/Nombre JOHN L SMITH		
	Medicare Number/Número de M 1EG4-TE5-MK72		
What is YOUR effective date for Medicare Part B?	PART A PART B	Coverage starts/Cobertura empieza 08-01-2021 08-01-2021	
	新发生的基础的表表的参数。	e en	
Do you currently have insurance coverage for prescription Federal Employees Health Benefit Plan/TRICARE for Life			
☐ NC State Employee Health Plan ☐ Retiree			
Please send my report to the family member/caregiver/e	to listed below		
Name:		: (
Address:		, , , , , , , , , , , , , , , , , , , ,	
Relationship:	Email:	· · · · · · · · · · · · · · · · · · ·	

Are you interested in learning about Medicare prescription drug coverage available through: Medicare Stand-alone Prescription Drug Plans Medicare Advantage Plans (Medicare, HMOs, PPOs, PFFS, etc.)					
In 2023, do you pay more than \$10.35 for brand name drugs and \$4.15 for generic drugs? Yes					
There are assistance programs available to help with prescription drug benefit costs. Does your monthly income level fall below \$1,843/single or \$2,485/married (living together)?					
Please provide us with information about your prescriptions and pharmacy. NOTE: You may be able to obtain a computerized listing from your pharmacist/pharmacy to attach. If not, please complete the chart below.					
NAME OF DRUG	STRENGTH	DAILY DOSAGE	FILL FREQUENCY		
Example: Lipitor	Example: 10 mg.	Example: Twice Daily	Example: Every 30 days		
I prefer to have my prescriptions filled at this pharmacy(s)					
Please check all that apply: I would be willing to use a different pharmacy. I prefer to use a mail order pharmacy. I live in a Long-Term Care Facility.					
NOTES					
For office use ONLY					
Username Password					

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