MEDICARE Rx DRUG COVERAGE COUNSELING TOOL

ship state health insurance assistance programs NATIONAL NETWORK

LOCAL HELP FOR PEOPLE WITH MEDICARE

AREA AGENCY ON AGING
REGION ONE, INCORPORATED

Name: _____ **Date:** _____

Address: _____ **City:** _____ **ZIP:** _____

Phone: _____ **Gender:** M F **Date of Birth:** _____

Medicare #: _____ - ____ - _____ ____ (suffix) **Effective Date:** Part A _____
Part B _____

Married? (Circle one) YES (include income & resources of couple) NO

Total monthly income: $_____ **Number of dependents:** _____

Total resources: (circle one) Less than More than **$13,440 (single) or $26,860 (couple)**

Do you receive SSI or are enrolled in a Medicare Savings Plan? (circle one) YES NO
If yes, you will automatically be eligible for Help with Medicare Prescription Drug Plan (PDP) costs.

Did you complete an application for Help with Medicare PDP Costs with the Social Security Administration? (circle one) YES NO

If yes, did your letter from Social Security state you are: (circle one)
ELIGIBLE for full subsidy ELIGIBLE for partial subsidy DENIED

Do you currently have insurance coverage for prescriptions? NO YES (Check all that apply)

☐ **Medicare Prescription Drug Plan**
Name of current Plan: _____

☐ **Medicare Advantage Plan (HMO or PPO) Name of current plan:** _____
If you are currently enrolled in a Medicare Advantage Plan, you must receive your drug coverage from that plan unless it is a private fee-for-service plan without drug coverage.

☐ **AHCCCS (Medicaid) If** you are a member of an AHCCCS health plan, you will automatically be enrolled in a Medicare prescription drug plan when your Medicare starts, if you do not choose a plan on your own.
Name of current AHCCCS Health Plan: _____ **AHCCCS #:** A_____

☐ **TRICARE for Life, VA Benefits, Federal Employees Health Benefit Plan (FEHBP)**
*If you have this type of coverage, it is almost always best to keep your current coverage without any changes and **not** enroll in a Part D plan at this time.* If YES, **STOP HERE**

☐ **Retirement Plan, Union Plan or Employer Group Health Plan**
Creditable coverage: Circle one If YES, **STOP HERE** If NO, **select PDP**
*If you have this type of coverage, you should check with your health plan. If it is creditable, then it is almost always best to keep your current coverage and **not** enroll in a Part D plan at this time.*

For office use only:

Drug List ID: _____ **Date:** _____

You prefer to join a: **(circle one)** DRUG PLAN ONLY MEDICARE ADVANTAGE PLAN

Your preferred pharmacy is: Name: _____
Address: _____

Your second choice is: Name: _____
Address: _____

You want a drug plan that offers mail order: YES NO
Is it important that the plan offers coverage at the beginning of the year with a zero or low deductible: YES NO

Name of Drug *Example: (Lipitor)*	**√ If Brand Name**	**√ If Generic**	**Strength** *(10 mg)*	**Daily Dosage** *(Twice daily)*

< Mail completed Counseling Tool to: OR Fax to: 602-241-5576
Area Agency on Aging, Region One
Benefits Assistance Program
1366 E. Thomas Rd., Suite 108
Phoenix, AZ 85014

< Results will be completed and mailed to beneficiary within 10 business days. Information will be limited to only the ***top 3*** Drug Plans or Health Plans that meet your specific needs.

The Benefits Assistance Program, part of the AZ SHIP program, does not recommend or endorse any particular drug plan or company and is not responsible for the service provided by these companies.