SHINE
Serving the Health Insurance Needs of Everyone

YOUR MEDICARE PLAN COMPARISON

ship state health insurance assistance programs
NATIONAL NETWORK
LOCAL HELP FOR PEOPLE WITH MEDICARE

IF YOU HAVE A "www.mymedicare.gov" ACCOUNT, INCLUDE IT HERE*:
USERNAME:_____PASSWORD:_____
***If you do not have an account, we will create one**

PLEASE PRINT

Name_____Date of Birth __ /__ /____ Age ____
Address_____ Zip Code_____
(Street) (Town) (State)
Phone_____

INFORMATION ON YOUR RED, WHITE & BLUE MEDICARE CARD (print clearly)
Medicare Number:_____
Note: There is no letter O; they are zeros

Coverage Start Date: HOSPITAL (Part A) _____ MEDICAL (Part B) _____

Name of pharmacy that you use: _____
Would you consider changing pharmacies if you could save on costs? Yes __ No __
Would you consider using a mail order pharmacy, if you could save on costs? Yes __ No __

Are you a Veteran? Yes __ No __
Are you enrolled in MassHealth (Medicaid)? Yes __ No __
Do you receive Extra Help (LIS)? Yes __ No __
Are you enrolled in Prescription Advantage? Yes __ No __

Your current insurance coverage:
Supplement/Medigap Plan Name of Plan: _____
Medicare Part D Plan Name of Plan: _____
Medicare Advantage Plan (Part C) Name of Plan: _____
GIC/Federal or Employer Retiree Plan Name of Plan: _____
Does your Retiree Plan provide prescription coverage? Yes __ No__ N/A__

OPTIONAL: You may be eligible for benefit programs that can help with your health care costs. If you provide information below, we will screen for benefit eligibility*:

Your (and spouse if applicable) monthly **gross** income:
Your monthly income: $_____ **Spouse monthly income**: $_____

*Assets may be a factor of eligibility.
We will inform you of the asset limits if it appears you may be eligible for benefit programs based on income listed.

Provide your list of medications on the other side of sheet →
Print clearly or attach a clearly printed list (ask your pharmacist). Drugs should be based on a 30 day supply.

IF MEDICATION MUST BE BRAND ONLY, PLEASE NOTATE. OTHERWISE GENERIC IS ASSUMED.

DRUG NAME As written on the bottle/pkg **Example**: Lipitor or Atorvastatin	**DRUG FORM** **Example:** Tab, Cap, Inj, Cream, Ointment, Lotion, Solution, Spray, Patch, etc.	**DRUG STRENGTH & DOSAGE** **Example:** 10 Mg. – one per day *If you use inhalers, insulin pens, drops, etc. state how many you get per month
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		

Mail this completed form:

Elder Services of the Merrimack Valley
ATTN: SHINE
280 Merrimack St., Suite 400
Lawrence, MA 01843

This area for SHINE office use:

Notes_____
_____
_____
_____
_____