PROVIDER AND MEDICATION WORKSHEET

Name: ____ Phone: ____________________

Address: ____ Date of Birth: _______________

City ____________________ State _____ Zip ___________ Email: _____________________

County: _____________________ Seasonal Home Zip / County: ______________________

Choose **one** of the following three options:

__ I will remain with Original Medicare and add a separate Part D drug plan and complete page 1 only

__ Or, enroll in a Medicare Advantage plan including Part D coverage (MAPD) and complete both pages

__ Or, enroll in a Medicare Advantage plan *without* Part D coverage (skip to page 2)

FOR PART D MEDICATIONS FULFILLED AT RETAIL PHARMACY

Check if applicable: [ ] I receive Social Security ***Extra Help*** for Part D premium, deductible and copays

[ ] My ***NY State EPIC*** ID is: EP__________________________

[ ] My ***NY State MEDICAID*** ID is: _______________________

MY PREFERRED LOCAL RETAIL PHARMACY:

[ ] CVS [ ] Walgreens [ ] RiteAid [ ] Price Chopper / Market 32 in _______________

[ ] WalMart [ ] Hannaford [ ] Other: ________________

Are there prescriptions you would like us to look up in a Part D drug list? [ ] Yes [ ] No

If yes, please exclude over-the-counter products and provide the exact spelling and complete information from the prescription label:

	Format	Dosage	Quantity
Ex: Atorvastatin	*tablet*	*125mg*	*2x daily*
1__________________________________	______	________	_______
2__________________________________	______	________	_______
3__________________________________	______	________	_______
4__________________________________	______	________	_______
5__________________________________	______	________	_______
6__________________________________	______	________	_______
7__________________________________	______	________	_______
8__________________________________	______	________	_______
9__________________________________	______	________	_______

Are you receiving **any PART B Medications** not fulfilled through your pharmacy? ___ NO ___ YES

Note: Part B medications may include a 20% co-share cost to you.

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Use additional pages if necessary

PROVIDER AND MEDICATION WORKSHEET

FOR MEDICARE ADVANTAGE PLANS

My Primary Care Provider Name: ____________________________________ Tel________________

Address ____ Medical Group __________________

My preferred area hospital for elective / non-emergency care: ________________________________

Any comprehensive dental care (excl cleanings) planned? ____ Yes ____No

SPECIALISTS I SEE

1) Name ____ Group ____________________

Address ____

2) Name ____ Group ____________________

Address ____

3) Name ____ Group ____________________

Address ____

4) Name ____ Group ____________________

Address ____

5) Name ____ Group ____________________

Address ____

Select the three most important features you look for in a health plan:

___ Dental Allowance beyond routine cleaning

___ $0 Drug Deductible

___ Nationwide Network of Doctors and Hospitals

___ Lowest Maximum Medical Annual Out of Pocket Costs

___ Hearing Aid Benefit

___ $0 Monthly Premium

___ Medicare Part B Rebate

___ Eyewear Allowance

___ Over-the-Counter Allowance

___ Other: ________________

Current Medicare Coverage is through : ____

What I like most about my current Medicare coverage: _____________________________

____

Features missing from my current Medicare coverage that I am looking for:

____

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