REQUEST FOR MEDICARE PART D DRUG PLAN COMPARISON

By completing this form, the requester will receive by mail, fax, or email, a Part D general comparison listing the three lowest annual cost plans as published on www.medicare.gov.The State Health Insurance Assistance Program (SHIP) is a program of the State's Department of Insurance and will provide this information at no cost and does not endorse any of the plans. This form should be mailed to: **State Health Insurance Assistance Program (SHIP) Attn: Angela Kirk, 311 W. Washington St., Suite 200, Indianapolis, IN 46204, faxed to 317-234-9633, or emailed to akirk@idoi.in.gov.** Please provide the following information:

Zip Code: _____ County: _____ Medicare Number_____

Do you get Extra Help Paying for Your Drug Costs? Not sure – see the bottom of the back page.
No ☐ Yes ☐ (Full ☐ Partial ☐) If Partial, what is the %_____

What type of Medicare do you receive now? Original Medicare ☐ Medicare Health Plan (PPO, HMO, etc.) ☐ No Medicare coverage yet ☐

Do you want your health and drug coverage together in one plan? (Medicare Health Plan PPO, HMO, etc) Yes ☐ No ☐

Do you want Prescription Drug coverage only? (Medicare Prescription Drug Plan)
Yes ☐ No ☐

Are generic Medications okay? Yes ☐ No ☐

Which pharmacy do you prefer? (You may enter up to 3) _____

Your Name: _____

Your Address: _____

City, State & Zip Code: _____

Your Phone Number: _____

PLEASE COMPLETE DRUG INFORMATION ON BACK OF THIS PAGE

OFFICE USE ONLY

Date Received: Processed Date: By: _____

Drug List ID: _____ Password: _____

Date emailed: Mailed: Faxed: .

Please list your drugs and dosages as they appear on your prescription bottle or package. Make sure that you spell the name of the drug correctly. **Do not include over-the-counter medications such as pain relievers and vitamins.**

DRUG NAME – this must be spelled correctly	DOSAGE	QUANTITY PER DAY

You may qualify for help with your Medicare costs. If your resources are less than $7,970 for an individual or $11,960 for a married couple living together and your monthly income is less than $2,006 for an individual or $2,706 for a married couple living together. For more information, contact SHIP at 1-800-452-4800.

Some plan's pharmacy networks offer limited access to pharmacies with preferred cost sharing in certain areas. The lower costs listed for medications in the completed comparison may not be available at the pharmacy that you use. For up-to-date information about a plan's network pharmacies, including pharmacies with preferred cost sharing, you will need to call the plan or consult their online pharmacy directory.

ship state health insurance assistance programs
NATIONAL NETWORK

LOCAL HELP FOR PEOPLE WITH MEDICARE